

Black Hills Health Care Health Professional Trainee Demographics

Please complete the information listed below and fax this form via secure fax to the Department of Education at 605-720-7188

Needs to be completed by at least *one month* prior to your requested clinical rotation date at the Black Hills Health Care System

___ I will be a Without Compensation Trainee

___ I will be a PAID student/resident/intern

<u>Training Program</u>	<u>Training Program</u>
Audiology	Rehab Medicine/Physical Therapy
Dentistry/Hygiene	Postgrad Residency/Fellowship
Laboratory	Radiology
Medical/Surgical Support	Social Work
Medical Student	Phlebotomy
Medical Resident	Advanced Practice Nurse (FNP)
Nursing LPN/RN/AND/BSN/MSN	Advanced Practice Nurse (CNL)
Optometry	Advanced Practice Nurse (CRNA)
Pharmacy	Advanced Practice Nurse (CNS)
Physician Assistant	Other:
Psychology	

Name of Institution: _____

Student/Trainee Information:

Program of Study: _____

___ Resident ___ Intern ___ N/A

Degree Level: _____

Trainee/Student's Legal Name: (First,MI,Last)

Anticipated Graduation Date: _____

Social Security Number: _____

Clinical Program Coordinator or Instructor Contact Information:

Telephone Number: _____

Name: _____

Email: _____

Phone: _____

The BHHCS Student Placement Coordinator (who agreed to rotation)

Email: _____

Name: _____

Department: _____

Privacy Act Statement: The execution of this form does not authorize the release of information other than that specifically described herein. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside BA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

___ TQCVL Received

Black Hills Health Care System Use Only:

___ Preceptor Agreement

___ Orientation Scheduled

___ Computer Access