Health Professional Learner Application Form

Today's Date: _____

GENERAL INFORMATION

OLOA Rotation Dept/Clinic *(check all that apply):*

Rotation Dates: _____

- ☐ Main Hospital
- ☐ Specialty Clinic
- ☐ General Surgery
- ☐ Family Medicine Clinic
- ☐ Emergency Room
- ☐ Other (specify)_____

IDENTIFYING INFORMATION

Last Name:	First Name:	Middle Initial:	Preferred Name:
Date of Birth:	Cell Number:	School E-Mail Address:	

ACCESS

Do you need EPIC EHR access for your clinical rotation? _____

If Current or Previous FMOLHS Employee (*please provide*):	If Prior FMOLHS EPIC Training (*please provide*):
Start Date: _____ End Date: _____	Date Trained: _____
FMOLHS Facility Name: _____	Location of Training: _____

EDUCATION

Name of School:	Program:	Current Year:
City:	State:	Anticipated Graduation Date:

EMERGENCY CONTACT

Name:	Relationship:	Phone:

APPLICANT SIGNATURE

Signature of Student Applicant: _____ Date: _____