Submit to: MedicalEducation@ochsner.org

PERSONAL DATA SHEET

Check One: ☐ Medical Student ☐ Nursing Student ☐ Allied Health Student ☐ Advanced Practice Clinician Student

Please complete all requred information.

Name: _____
Last First MI

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Date of Birth: _____ *SSN: _____ Citizenship:_____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number(s): _____

*Entire SSN is required of all students for Ochsner's internal academic administrative purposes only.

College/University: _____

Program of Study: _____ Expected Graduation Date: _____
(MM/YYYY)

Clinical Department/Rotation:_____

Dates of Rotation - Start: __ / __ / __ End: __ / __ / __ Approx. Number of Hours: _____
MM DD YY MM DD YY (Allied Health, APC, & Nursing Students Only)

Location(s) of Clinical Rotation:

☐ Ochsner Medical Center (Main Campus)
☐ Ochsner Medical Center - Kenner
☐ Ochsner Medical Center - Baton Rouge
☐ Ochsner Medical Center - West Bank
☐ Ochsner Health Center (**Clinics**): (Select Clinic)
(Select Clinic From Drop Down List)

☐ Ochsner Medical Center - Northshore
☐ Ochsner Baptist Medical Center
☐ Ochsner Hospital - Elmwood
☐ Ochsner St. Anne General Hospital

This section to be completed by nursing students only:

Check One: ☐ MA ☐ LPN ☐ ADN ☐ BSN ☐ APRN ☐ MSN/MN **Rotation Type:** ☐ Group ☐ Preceptorship

Instructor's Name: _____ Instructor's Phone Number: _____

Preceptor's Name: _____ Preceptor's Phone Number: _____

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