

Type in information and save to your computer.  
Then submit electronically to **Instructor/Advisor**

**Student/School/Faculty Information Sheet**

**Student Information:**

Date:	
Name (enter first, middle & last):	
Address:	
Telephone #:	Email:
Date of Birth:	
Last 4 SSN/ID	Nursing License # if applicable:
Liability Insurance Carrier: If provided by school leave blank	
Have you ever been employed by Novant Health?	Yes                  No

**Educational Facility:**

Educational Facility:	
Educational Program:	Graduation Date:
Supervising Faculty:	
Faculty Email Address:	
Rotation Service/Course Name:	
Rotation Dates:	Start Date                          End Date
Total number of Hours:	

**Rotation Facilities:**

<b>Select the primary Novant Health facility where you most likely will be rotating:</b>	
<b>Select the secondary Novant Health facility where you may be rotating:</b>	
If NHMG specify practice:	
Dimensions training completed (check all that apply): Amb    Acute IP    OB/GYN    ED Surgery    View Only    none	Rotation in Practice only Rotation in Acute Care Facility only Rotation in Practice and Acute Care

**Supervising Physician/Preceptor:**

Preceptor's Name:	
Preceptor's email address:	
Preceptor's Telephone #:	
Supervising Physician/ Preceptor's Office Address:	