Student Application for PHC

Personal Information

Full Name: _____
First Middle Initial Last

Address: _____
Street Address Apt/Suite

_____
City State Zip Code

E-mail Address: _____

Are you at least 18? Y ☐ N ☐ **Phone Number:** _____

Anticipated Dates and Hours: _____

Emergency Contact Information

Name: _____ **Relation**: _____

Phone Number: _____

Program Information

Name of School: _____ **Required by School:** ☐**Yes**

Address: _____
Street Address Apt/Suite

_____
City State Zip Code

School Clinical Course Contact & Position: _____

E-mail Address: _____

Phone Number:_____ **Current Program of Study:**_____

Partnership Health Center will internally only share your name, school, a biography, photo and the duration of your time with its employees. In accordance with FERPA, If you would not like your information to be shared, please check the box below.

☐ I do not consent to Partnership Health Center sharing my information internal

Any Additional Comments:

SIGNATURE_____**DATE** _____

PRINT NAME _____

For Official Use Only – Do Not Complete

Student or Shadow: _____

Required Hours: _____

Anticipated Start Date:_____-_____-____ **Anticipated End Date:**_____-_____-____

Department & Supervisor at PHC: _____

Other Supervisory Notes:
