Lakeridge Health

Lakeridge Health Student Data Form

STUDENT TO COMPLETE AND RETURN TO ACADEMIC AFFAIRS ON START DATE

1. Demographics

Full Name (please print; underline surname):

Present Mailing Address:	Telephone:
	Email Address:
Emergency Contact:	Emergency Contact Telephone:
Approved Respirator Type:	Test Date:

2. Academic Program Information

Academic Institution:	Training Level:
Program of Study:	Expected Year of Graduation:

3. Practicum Information

Practicum Start Date:	Practicum End Date:	Required # of Practicum Days_____ or Hours _____

LH Clinical Program/Service:	Unit:	LH Site:
LH Preceptor:	Phone/Ext or Pager Number:	
Academic Center Contact/Co-ordinator:	Phone/Ext:	

Will you be participating in a research, quality improvement or program evaluation project during this time? : Yes / No, If YES, provide title of project:

4. **Statement of Acknowledgement:** I acknowledge that I have reviewed the LH required documents PDF on the Confirmed Placement page on our website and hereby confirm that I have read and understand the contents in its entirety.

Student's Printed Name Student's Signature Date