Lakeridge Health

Lakeridge Health Medical Trainee Data Form

Section 1: Demographics

Name:			
Address:			
City:		Province:	
Postal Code:		Phone:	
Email:		Date of Birth:	
Emergency Contact:		Emergency Phone:	

Section 2: Prerequisites

Approved Respirator Type:		Test Date:	
Flu Shot (10 Oct. - 30 Apr.):	◯ Yes ◯ No	Date of Immunization:	
CMPA #:		CPSO #:	CFPC #:

Section 3: Academic Program Information

Academic Institution:		Program of Study:	
Student Number:		Training Level:	

Section 4: Rotation Information

Start Date:		End Date:		LH Site:	
LH Program/Service:			LH Preceptor:		
Will you be participating in a placement at another Health Care Organization during this time?				◯ Yes	◯ No
Will you be participating in a research project during this time?				◯ Yes	◯ No

Section 5: Statement of Acknowledgement

I acknowledge that I have received the LH Medical Trainee Orientation Package (online/hardcopy), and hereby confirm that I have read and understand the contents in its entirety.

Name	Signature