Mary Lanning Healthcare
Student Provider Clinical Rotation Documentation

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____ Last four digits of Social Security Number:_____

Home Phone:_____ E-mail:_____

College:_____

Hometown:_____

Specialty Interest:_____

_____

Anticipated Date of Graduation:_____ Preceptor:_____

Rotation Dates:_____

_____

Confidentiality Statement: I, _____ pledge to observe appropriate rules of conduct and maintain confidentiality before, during, and after my shadowing experience at Mary Lanning Healthcare (MLH). As a student considering a career as a health care professional, I understand the importance of confidentiality and will uphold the standards within the profession. In addition, I release the hospital of any liability while I am on hospital grounds and I verify that I have the following up to date immunizations: measles, mumps and rubella (MMR); chicken pox (varicella) or history of the disease; Hepatitis B; tetanus / diphtheria; COVID vaccine or signed declination form.

Note: MLH may require proof of vaccines if requested by Employee Health department.

Student Provider Signature:_____ **Date:**_____

If future clinical rotations are scheduled, and to determine if additional paperwork may be required or Mary Lanning Healthcare access needs arranged, please contact:

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