

# EINSTEIN HEALTHCARE NETWORK

## STUDENT AFFILIATE INFORMATION FORM

Date \_\_\_\_\_

- EMCP – Philadelphia Campus
- EMCEP - Elkins Park Campus
- EMCM – Montgomery Campus
- Moss Rehab - EP \_\_\_\_ Tabor \_\_\_\_
- Willowcrest
- Other: \_\_\_\_\_

### **PERSONAL INFORMATION:**

FIRST NAME \_\_\_\_\_ LAST NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY / STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
TELEPHONE NUMBER (CELL) ( ) \_\_\_\_\_ STUDENT TYPE:  MS4  MS3  PA  Nursing  Other  
EMAIL ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
ROTATION \_\_\_\_\_ DATES OF ROTATION \_\_\_\_\_

### **EMERGENCY CONTACT INFORMATION:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
TELEPHONE NUMBERS (HOME) ( ) \_\_\_\_\_ (CELL) ( ) \_\_\_\_\_

### **EDUCATION:**

NAME OF COLLEGE/UNIVERSITY/TECHNICAL SCHOOL \_\_\_\_\_  
SCHOOL CONTACT \_\_\_\_\_ TELEPHONE ( ) \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_

### **PLEASE READ CAREFULLY BEFORE SIGNING**

1. Placements are contingent on the Student Affiliate's School Program agreement with EHN (Einstein Healthcare Network), verification of required documentation and a criminal background check, as stated in the Student Affiliate Requirements.
2. I am freely participating as a student affiliate at EHN. I understand that I must abide by all the policies, procedures and regulations of EHN.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### **To be completed by the Office of Academic Affairs:**

Department \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

