

Student Types (please select all that apply)

Postgraduate Medical Trainee	Nursing	Undergraduate Medical Student	Health Disciplines	Midwifery Students
<input type="checkbox"/> Resident : PGY Level _____ <input type="checkbox"/> Chief/Senior Resident <input type="checkbox"/> Clinical Fellow <input type="checkbox"/> Research Fellow <input type="checkbox"/> PEAP <input type="checkbox"/> Off-Site On-Call <input type="checkbox"/> Medconnections <input type="checkbox"/> Clinics	<input type="checkbox"/> Yr. 1 <input type="checkbox"/> Yr. 2 <input type="checkbox"/> Yr. 3 <input type="checkbox"/> Yr. 4 <input type="checkbox"/> Pre-grad <input type="checkbox"/> Post-grad <input type="checkbox"/> 2 nd Degree Entry <input type="checkbox"/> Observational	<input type="checkbox"/> Yr. 1 <input type="checkbox"/> Yr. 2 <input type="checkbox"/> Yr. 3 (CC3) <input type="checkbox"/> Yr. 4 (CC4) <input type="checkbox"/> Observational <input type="checkbox"/> Elective	<input type="checkbox"/> Health Disciplines Program <input type="checkbox"/> Paramedics <input type="checkbox"/> Observational <input type="checkbox"/> Administration <input type="checkbox"/> Research <input type="checkbox"/> Co-op Student <input type="checkbox"/> Other: _____	<input type="checkbox"/> Clerk <input type="checkbox"/> Yr. 1 <input type="checkbox"/> Yr. 2 <input type="checkbox"/> Yr. 3 <input type="checkbox"/> Yr. 4 <input type="checkbox"/> Yr. 5

Personal Data

First Name: _____ Last Name: _____ Gender: _____

Address: _____ Postal Code: _____

Home Number: _____ Cell Number: _____ Pager: _____
(as applicable)

Email Address: _____

Academic Program Information

Academic Institution: _____ Program: _____

Student Number: _____

If UofT Medical student, Name of Academy: _____

Rotation Information

Start Date: _____ End Date: _____

Unit/Area/Service: _____ Supervisor/Clinical Instructor Name: _____
(Primary Accountability for Student) On-site Off-site

of Hours on Site: _____ Supervisor Contact #: _____

Orientation Information

Mask Fitted (Yes or No): _____ If yes indicate date & location: _____

Size: _____ Model: _____

Mask Fitted but no confirmation (please sign): _____

I hereby acknowledge that I have been mask fit tested within the past 18 months at another facility. If requested, I can provide confirmation of this fitting at a later date and I am aware of my mask type and size

I hereby acknowledge that I have participated in a St. Michael's Hospital Infection Control Training Session

I hereby acknowledge that I have participated in an Infection Control Training session at another facility
Please indicate date & location of session: _____

Do you have Liability Insurance (Yes or No): _____ (As applicable)

Have you had your TB skin test in the past 12mths? Yes or No): _____ (Nursing & Health Disciplines students only)

Emergency Contact

Name: _____ Relationship: _____

Home#: _____ Cell #: _____ Business #: _____

Address: _____

Postgraduate Medical Trainees

CMPA Number: _____ CPSO Number: _____ License: Educational General

Code: _____ (code 12 -is for trainees who do **NOT** moonlight code 14 -is for trainees who do moonlight code 13 -is for clinical fellows who do **NOT** moonlight)

Academic Half Day: _____ Name of Institution where MD obtained: _____

Health Disciplines Students

Length of Placement (total # of days): < 1 day 2-5 days 6-15 days > 15 days

Additional Educators

Name: _____ Name: _____

Contact #: _____ Contact #: _____

Unit/Area/Service: _____ Unit/Area/Service: _____

Midwives

Midwife Preceptors: Access Midwives Community Midwives Kensington Midwives
 Riverdale Community Midwives Interprofessional Placement

For Student Centre Internal Use Only (Referral Source)

Academic (Partner) Volunteer Services Self-Referred Research Academic (Non-Partner)

Barcode Registry Date: _____ Student Database Date: _____