Provider Level Student Rotations

Student Type: (Circle One)	Medical	Physician Assistant	Nurse Practitioner	Nurse Midwifery	Nurse Anesthetist
Student Name:					
Preceptor Name: (Print Legibly)					
Rotation Dates: (Month, day, year)					

Location: (Circle all that apply)	Hospital OR or Cath lab	Labor & Delivery	Hospital Floor
	ASC	LMC Physician Network Practice	ED

Activity: (Circle One)	Observation only	If observation only, **STOP HERE**
	Patient Contact	**COMPLETE REMAINDER OF FORM**
Affiliation Agreement with school: (Circle One)	Yes	Please attach a copy of Student's school ID badge to this form
	No	If No, stop here. Without a contract from their school of origin, students are limited to observation only.
Student's proposed clinical activities while on LMC campus:	• • • •	

By signing below, both student and preceptor acknowledge that the student has received orientation to LMC (HIPAA, Breach of Confidentiality, Code of Conduct, Fire Safety, etc.)

_____ Student Signature	_____ Date	_____ Manager or Director Signature	_____ Date
_____ Preceptor Signature	_____ Date	_____ Manager or Director Signature	_____ Date
		_____ Manager or Director Signature	_____ Date
		_____ Manager or Director Signature	_____ Date