Student Application Date Completed: _____

Please return completed form to: St. Anthony Education Services:
311 South Clark St., P.O. Box 628, Carroll, IA 5140; Telephone: 712.794.5243; Fax: 712.794.5541;
Email: education@stanthonyhospital.org

For office use only
Approval:_____
Date:_____
Preceptor:_____

Please type or print clearly

Last Name	**First Name**	**MI**	
Address	**City**	**State**	**Zip**
Primary Phone #	**Current Email**	**Permanent Email**	
In what educational institution are you currently enrolled?		**Graduate Major(s)**	
Undergraduate College(s) Attended (include City/State)		**Undergraduate Major(s)** **Undergraduate Minor(s)**	

Currently in which Educational Level (Select one from each column)

(Select one)	**(Select one)**	**Anticipated Date of Graduation** (mm/dd/yyyy)
☐ Certificate ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctoral ☐ Other: Specify_____	☐ Student, Pre-Health Program ☐ Student, Enrolled in Any Health Professions Program ☐ Intern ☐ Resident ☐ Fellow ☐ Other: Specify_____	

Health Profession Discipline (Select only one)

☐ Allopathic Medicine	☐ Nurse Midwife	☐ Community Health Worker	☐ Clinical Lab Worker
☐ Chiropractic	☐ Nurse Practitioner (NP)	☐ Health Education/Behavior	☐ EMT – Paramedic/First Responder
☐ Osteopathic General Practice	☐ Registered Nurse	☐ Health Services/Hospital Administration	☐ Health Information Systems/Data Analysis
☐ Optometry	☐ Dental Assistant	☐ Nutrition – Dietetics	☐ Occupational Therapy
☐ Pharmacy	☐ Dental Hygiene	☐ Public Health (General Studies)	☐ Physical Therapy
☐ Podiatry	☐ General Dentistry		☐ Radiology
☐ Psychiatry	☐ Clinical Psychology		☐ Other, specify below:
☐ Veterinary Medicine	☐ Clinical Social Work		_____
☐ Physician Assistant	☐ Substance Abuse – Addictions Counseling		
☐ Licensed Practical/Vocational Nurse (LPN/LVN)			

In the future, I would be interested in working at St. Anthony ☐ Yes ☐ No

Clinical Dates Requested (mm/dd/yyyy) **(Required)** Start End	**Total hours (not weeks) you plan to work at St. Anthony (Required)**

Rotation/Course/Clinical Description

Rotation/Course Name

What do you, the student, want to achieve during your clinical experience? (Required)

List specific experiences required by Rotation/Course (attach course objectives, if available)

Service Learning/Community Service/Community Engagement as part of the course requirement?

☐ Yes ☐ No

Educational Institution/Organization

☐ Educational Institution Name: _____

☐ Other Organization Name: _____

Educational Institution/Organization Address

City State Zip

Academic Course Coordinator

Name	**Phone**	**Email Address**

Training/Clinical Site

Location or Site Requested:

I have received training on Blood Borne Pathogen Prevention ☐ Yes ☐ No ☐ Don't Know

I have received training on Mandatory Child and Adult Abuse Reporting ☐ Yes ☐ No ☐ Don't Know

Do you have a record of founded child or dependent adult abuse? ☐ Yes ☐ No

Have you ever been convicted of a crime in this state or any other state? ☐ Yes ☐ No

_____

Student Signature: _____ Date: _____