HEALTH PROFESSIONAL TRAINEE INFORMATION

NAME (First Middle Last): _____

OTHER NAMES OF RECORD: _____

FOREIGN NATIONAL: ☐ Yes ☐ No ☐ US Citizen

DUAL CITIZENSHIP: ☐ Yes ☐ No

GENDER: Choose Item **BIRTHDATE:** _____

CITY OF BIRTH: _____ **STATE OF BIRTH:** _____

COUNTRY OF BIRTH: _____

RACE: _____ **SOCIAL SECURITY NUMBER:** _____

LOCAL ADDRESS: _____

LOCAL PHONE: _____

EMAIL(S): _____

HEIGHT: _____ **WEIGHT:** _____ **HAIR COLOR:** _____ **EYE COLOR:** _____

SUPERVISOR: **ASSIGNED CLINIC:**

POSITION WHILE AT VHASAG: Choose Item

ROTATION START DATE: _____ **END DATE:** _____

MEDICAL LICENSURE NUMBER: _____

CONTROLLED SUBSTANCE LICENSURE NUMBER: _____

SCHOOL: _____

ANTICIPATED DEGREE: _____

PAST VA AFFILIATION? Choose Item

VETERAN ☐ Yes ☐ No ☐ Navy ☐ Army ☐ Air Force ☐ Marine ☐ CG