Clinical Trainee Registration Form

Please complete this form for every trainee regardless of type of appointment or pay status (i.e. paid directly by VA, paid via disbursement agreement or without compensation) or length of training.

First Name:_____ M.I.:_____ Last Name:_____

Targeted Degree: Please check appropriate program of study for **this VA clinical rotation**:

_____ Nurse Aid

_____Nurse Technician

_____LVN/LPN

_____Nursing Associate

_____Nursing Bachelor

_____Master in Nursing Anesthesia

_____Master in Nurse Practitioner

□ Specialty_____

_____Master in Nursing

□ Specialty _____

_____Doctoral

□ DNP

□ DNS

□ PhD

Email Address:_____ Phone Number:_____

Paid for this clinical rotation? □ Yes □ No Work without compensation? □ Yes □ No

VA Rotation Starting Date: _____ VA Rotation Ending Date: _____

Month Day Year Month Day Year

Name of School: _____

Name of Teacher (for this course/rotation at school):_____

Total Clinical Hours for Current Rotation at VA:_____