

Clinical Student/Instructor Roster

School Name: _____ Date: _____

Program Name: _____

Clinical Rotation and/or Internship Dates: Begins: _____ Ends: _____

CFVH Preceptor/Mentor's Name: _____ Dept: _____

Rotation Location: _____ **Confirmed Rotation** # _____

	Returning Student <i>If yes, last rotation date</i>	Print Student Name		Last 5 Digits SS#	Assigned Badge # Office Only	Predicted Graduation Date : mm/dd/yy
		Last Name	First Name			
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

The signature below verifies that before a clinical or non-clinical rotation/internship can begin and to obtain an ID badge **ALL** students and instructors must be **CLEARED** in Rotation Manager **two weeks** before the rotation start date.

School's Instructor/Representative:

Name (*print*): _____ Phone #: _____

Email address: _____