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| This information will be kept confidential. It will be used for reporting purposes, conducting surveys, and improving the quality of VHA’s clinical training programs. This information will be entered in the “New Person” file in Veterans Health Information Systems and Technology Architecture (VistA) and must be submitted 4 weeks before starting your rotation. |
| Disclosure of your Social Security Number (SSN) is mandatory to identify individuals with identical names. Failure to provide this information may delay or make impossible the proper application of Civil Service rules and regulations and VA personnel policies and thus may prevent you from obtaining clinical training at VA. Solicitation of the SSN is authorized under the provisions of Executive Order 9397, dated November 22, 1943. The information gathered through the use of this number will be used as necessary for statistical studies and personnel administration in accordance with established regulations and published notices of systems of record. |

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| VA_Signature_Black_on_White_150dpi_2-5in | STAFF/TRAINEE REGISTRATION INFORMATION FOR VISTA  Please Read, Complete and Submit the form ASAP |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name( Print)** | | | **Full Middle Name (Print)** | | | **Last Name (Print)** | | | |
|  | | |  | | |  | | | |
| Social Security Number | **DOB: mm/dd/yyyy** | | | | Gender (M/F) | | **Race:** | | **Height:** |
| Country of Citizenship: | **Place of Birth: City/State/Country** | | | | Weight: | | Eyes: | | Hair: |
| Cell: | | | **Pager:** | | | **NPI:** | | | |
| Permanent Street Address: | | | | **Email Address(Print)** | | | | | |
| City: | | | | **State** | | | | **Zip** | |
| Affiliated School: (GW) (GU) (HU) (USUHS) Other: | | | | **Affiliation Point of Contact & Phone number:** | | | | | |
| **PPD Test & Date:** | | | **BCLS :**  **Date Completed:** | | | **ACLS:**  **Date Completed:** | | | |
| Rotation Site *i.e. Inpatient/Outpatient/Specialty Clinic*: | | | | | | | | | |
| **Start Date:(mm/dd/yyyy)**  07/01/2016 | | End Date:(mm/dd/yyyy) 06/30/2019 | | **What is the LAST MONTH and YEAR that you anticipate being in a training program at this VA facility? (mm/yyyy)** | | | | | |

**Target Degree Level of your current training program:** *(mark only one)*

|  |  |
| --- | --- |
| ⭘ Certificate/Diploma  ⭘ Associate | ⭘ Post-master’s fellowship  ⭘ Doctoral |
| ⭘ Baccalaureate  ⭘ Master’s | ⭘ Postdoctoral (other than residents)  ⭘ Residency/Fellowship |

**Program of Study:** *(mark only one) (Discipline that best describes the current program of study)*

|  |  |
| --- | --- |
| ⭘ Audiology  ⭘ Chaplaincy | ⭘ Medical/Surgical Support (Respiratory  Tech, Biomedical Tech, etc.) |
| ⭘ Dental Resident *(all other dental select Other Clinical Program)* | ⭘ Nurse Anesthetist |
| ⭘ Dietetics | ⭘ Nursing |
| ⭘ Health Information | ⭘ Optometry |
| ⭘ Health Services Research & Development | ⭘ Other Clinical Program |
| ⭘ Imaging (Radiologic/Ultrasound Tech, etc.) | ⭘ Pharmacy |
| ⭘ Laboratory | ⭘ Physician Assistant |
| ⭘ Medical Student (3rdYr) (4thYr) - *circle one* | ⭘ Podiatry |
| ⭘ Medical Resident/Fellow PGY-\_\_\_\_ | ⭘ Psychology |
| ⭘ Medical Post-residency Physician in a VA  Special Fellowship (Ambulatory Care, National  Quality Scholars, Women’s Health, etc.) | ⭘ Rehabilitation (OT, PT, KT, etc.)  ⭘ Social Work  ⭘ Speech–Language Pathology |