KAISER PERMANENTE® thrive

OUTPATIENT STUDENT PLACEMENT PROGRAMS
GREATER SOUTHERN ALAMEDA AREA

Student Placement Request & Information Sheet – Greater Southern Alameda Area

Please type or print the form using Black or Blue Ink only.

SCHOOL CONTACT INFORMATION

SCHOOL NAME: _____

DESIGNATED REPRESENTATIVE: _____

PHONE NUMBER: _____

EMAIL ADDRESS: _____

STUDENT INFORMATION

LEGAL NAME: _____
(first name) (middle) (last name)

ADDRESS: _____

PHONE NUMBER: _____ ALT. NUMBER: _____

EMAIL ADDRESS: _____

STUDENT ROLE FOR CLINICAL ROTATION INFORMATION

_____**Audiologist** _____**Chaplain** _____**CNM** _____**CRNA** _____**Dietician** _____**EKG Tech**

_____**Medical Assistant** _____**Nurse Practitioner** _____**Pharmacist** _____**Phlebotomist**

_____**Physician Assistant** _____**Physical Therapist** _____**Radiology** _____**Respiratory Therapy**

_____**Social Worker** _____**Sterile Processing** _____**Surgical Tech** _____**Other**

MUST SPECIFY STUDENT ROLE IF "OTHER" IS CHECKED: _____

LOCATION PREFERENCE: _____Fremont _____Hayward _____Union City _____San Leandro

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

EXACT TOTAL NUMBER OF CLINICAL HOURS YOU MUST COMPLETE: _____

SCHEDULING RESTRICTIONS AND AVAILABILITY (i.e., Employment) _____

NO EXCEPTIONS – REQUIRED INFORMATION – MUST HAVE VALID SSN OR I-20

DATE OF BIRTH: _____/_____/_____ **SOCIAL SECURITY NUMBER:** _____/_____/_____

1. Has the student ever been employed by Kaiser? YES ☐ NO ☐
2. Has the student had previous Kaiser clinical experience? YES ☐ NO ☐
3. Did the student successfully complete Health Connect Training? YES ☐ NO ☐

_____ _____
(Signature required) (Print Legal Name) (Date)

***I certify that I have validated the accuracy of the information being provided.**

KAISER OFFICE USE ONLY

Approved: _____ Not Approved School Notified: _____

Manager: _____ Tieline: _____ Dept: _____

SUBMIT REQUEST FORM 4 - 6 WEEKS PRIOR TO YOUR DESIRED START DATE

Outpatient Student Placement Phone: 510-675-5739/6844 Fax: 510-675-6673