DENTAL STUDENT INFORMATION FORM

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER

PLEASE PRINT!

IS THIS YOU'RE FIRST ROTATION WITH THE HOSPITAL INDICATED ABOVE? ☐ YES ☐ NO

If no, please name previous Clerkship/Elective & Academic Year _____

DENTAL STUDENT DEMOGRAPHICS

Last Name	First Name	Middle	Year in Program for scheduled dates	Year in Program for scheduled dates
			☐ D3 ☐ Clerkship	☐ D4 ☐ Elective

Clerkship/Elective Name	Clerkship/Elective Dates	Social Security Number	Gender
		_____ - _____ - _____	☐ M ☐ F

Current Street Address	City	State/Zip	Home Phone No.	Fax No.
			( )	( )

Primary E-mail	Secondary E-mail	Pager No.	Cellular No.
		( )	( )

DENTAL EDUCATION

Dental School & State	Expected Graduation Date	Scrub Size	Scrub Code
		☐ S ☐ M ☐ L ☐ XL ☐ XXL	_____

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Dental Student	Home Phone No.	Work Phone No.	Cellular No.
		( )	( )	( )

STOP ~ DO NOT WRITE BELOW THIS LINE

X _____ _____

Program Approval/ signature for accepting dental student for this clerkship/elective

Date

Received by Medical Education Dept. _____