# MEDICAL STUDENT INFORMATION FORM

**Please provide the following information regarding your last Advocate rotation:**
Site: ________________
Rotation: ________________
End Date: ________________
☐ This is my first rotation at an Advocate site.

(Please indicate with an X, the Advocate site where you will be rotating)

| | | |
|---|---|---|
| ☐ Advocate Medical Group Office | ☐ Good Samaritan Hospital | ☐ Lutheran General Hospital |
| ☐ Christ Medical Center | ☐ Good Shepherd Hospital | ☐ Trinity Hospital |
| ☐ Condell Medical Center | ☐ Illinois Masonic Medical Center | |

**PLEASE PRINT!**

## MEDICAL STUDENT DEMOGRAPHICS

| Last Name | First Name | Middle | Date of Birth (Month/Day/Year) ____/____/____ | Gender ☐ M ☐ F | Social Security No. (last 5 digits only) __ - ______ |
|---|---|---|---|---|---|

| Name of Rotation | Rotation Dates (start and end) | Type of Rotation ☐ Clerkship ☐ Sub-I ☐ Elective ☐ Other | Name of Preceptor |
|---|---|---|---|
| **Current Street Address** | **City** **State/Zip** | **Cellular Phone No.** | **Home Phone No.** |
| **Primary E-mail** | **Secondary E-mail** | **License Plate No./State** | **Scrub Size (small-XXL)** |

## MEDICAL EDUCATION

| Medical School & State | Expected Graduation Date | Year in Medical School for scheduled rotation ☐ M1 ☐ M2 ☐ M3 ☐ M4 |
|---|---|---|

## IN CASE OF EMERGENCY

| Name of Local Friend or Relative | Relationship to Medical Student | Cellular Phone No. | Home Phone No. | Work Phone No. |
|---|---|---|---|---|

X ______________________________________________ ______________
**Department/Program Approval ( If Applicable)** **Date**

**Received by Medical Education Dept.** ______________________

Revised 2/14