

Penrose-St. Francis Health Services



Student's name: _____

Field of Study (PT, RN, PharmD, PA, Med Student, etc.) _____

Earliest start date: _____

Latest completion date: _____

Total number of hours required: _____

Facility: (please circle/underline) Penrose Hospital or St. Francis Medical Center

Department: _____

Name of PSF person that approved internship: _____

We have on file at the school (check/fill-in applicable line):

MMR x 2 ____ & ____ or positive titer _____

Varicella: positive history of chicken pox ____ positive titer ____ chicken pox vaccine ____

Hep B x 3 ____ or declination _____

TB within one year: Date read ____/____/____

Criminal background check (including National Criminal Database search with National Registered Sex Offender search and Healthcare Sanctions [OIG and GSA]

Report): Clear _____ Not Clear _____

BLS card: Date expires _____

Influenza Vaccine (required October through March):

Date _____ Medical Exemption _____

Name of person emailing letter: _____

Email address: _____

Phone number: _____

Name of school: _____