

# Cheyenne VAMC Health Professional Trainee Demographic Form

**Please complete the information listed below and fax this form via secure fax 307-772-7738 Attn: Designated Learning Officer, at least one month prior to your requested clinical rotation date at the Cheyenne VAMC.**

I will be a Without Compensation Trainee       I will be a PAID student/resident/intern

**PROGRAM INFORMATION**

NAME OF INSTITUTION: \_\_\_\_\_

PROGRAM OF STUDY: \_\_\_\_\_

DEGREE LEVEL: \_\_\_\_\_

ANTICIPATED GRADUATION DATE: \_\_\_\_\_

CLINICAL PROGRAM COORDINATOR OR INSTRUCTORS CONTACT

INFORMATION:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

CLINICAL ROTATION DATE(S) REQUESTED: \_\_\_\_\_ to \_\_\_\_\_

**STUDENT/TRAINEE INFORMATION:**

I am:     Resident     Intern     N/A

TRAINEE/STUDENT'S LEGAL: FIRST (MIDDLE INITIAL) LAST NAME

\_\_\_\_\_

SOCIAL SECURITY NUMBER

TELEPHONE NUMBER: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

THE VAMC "**CLINICAL**" POINT OF CONTACT WHO AGREED TO YOUR ROTATION:

CHEYENNE VAMC DEPARTMENT: \_\_\_\_\_

NAME: \_\_\_\_\_

If you would prefer to e-mail this form you understand and accept that, although very minimal, there is a risk that your information could potentially be intercepted en-route to us. [CFEDpublic.website@va.gov](mailto:CFEDpublic.website@va.gov)

**PRIVACY ACT STATEMENT:** The execution of this form does not authorize the release of information other than that specifically described herein. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

<b>Training Program</b>	<b>Code</b>
<input type="checkbox"/> Audiology/Speech Path	06
<input type="checkbox"/> Dentistry/Hygiene	30
<input type="checkbox"/> Dietetics	10
<input type="checkbox"/> Health Information (Med Rec.)	11
<input type="checkbox"/> Imaging	14
<input type="checkbox"/> Medical Laboratory	15
<input type="checkbox"/> Medical/Surg Support	17
<input type="checkbox"/> Medical Student	03
<input type="checkbox"/> Medical Resident	01
<input type="checkbox"/> Nursing LPN/RN/ADN/BSN/MSN	21
<input type="checkbox"/> Optometry	22
<input type="checkbox"/> Pharmacy	23
<input type="checkbox"/> Physician Assistant	24
<input type="checkbox"/> Psychology/Mental Health	18
<input type="checkbox"/> Rehab Medicine	27
<input type="checkbox"/> Postgrad Residency / Fellowship	30
<input type="checkbox"/> Radiological Technology	14
<input type="checkbox"/> Social Work	28
<input type="checkbox"/> Phlebotomy	15
<input type="checkbox"/> Respiratory Therapy	17
<input type="checkbox"/> Advance Practice Nurse (FNP)	21
<input type="checkbox"/> Advance Practice Nurse (CNL)	21
<input type="checkbox"/> Advance Practice Nurse (CRNA)	19
<input type="checkbox"/> Advance Practice Nurse (CNS)	21
Other: _____	30

**Cheyenne VAMC Use Only:**

TQCVL Received                       Preceptor Agreement                       Computer Access  
 Orientation Scheduled                       Student DB