BLUEWATER HEALTH

REGISTRATION FOR CLINICAL PLACEMENT

STUDENT/RESIDENT INFORMATION

Last Name: _____

First Name: _____

Address: _____

_____

Phone: _____ email: _____

Emergency Contact Name and Phone: _____

_____

Student/Resident Signature: _____

Start Date: _____ Finish Date: _____

CPSO # _____ CMPA #: _____

University Affiliation: _____

Student Number: _____

Postgrad or Undergrad Year: _____

Training Program: _____

Hospital Program/Service: _____

SUPERVISOR'S NAME: _____

Supervisor Contact Phone Number: _____

Return to: Medical Affairs at medical_affairs@bluewaterhealth.ca or Fax: 519-464-4501