WEST PARRY SOUND HEALTH CENTRE

EDUCATION PLACEMENT FORM

STUDENT NAME: _____

HOME PHONE: _____ **CELL:** _____

HOME ADDRESS: _____

_____

EMAIL: _____

IN CASE OF EMERGENCY NOTIFY: _____

PHONE: _____

STUDENT SIGNATURE: _____

PROGRAM TITLE: _____

SCHOOL/INSTITUTION: _____

FACULTY/TEACHER CONTACT: _____

PHONE: _____ **EXT:** _____

EMAIL: _____

ASSIGNED DEPARTMENT: _____

START DATE: _____ **END DATE:** _____

SUPERVISOR: _____

SUPERVISOR'S SIGNATURE: _____

AMBULANCE CREW (EMS ONLY): _____