



San Juan Regional Medical Center requires the following information from each student so that they may be entered into our computer system for tracking. This information is needed for production of an identification badge. This information is used for these sole purposes and will not be shared in any other manner. Please print the following information in the spaces provided. If you have any questions, please contact 505-609-6473. Your call will be directed to the appropriate person. Thank you.

I agree to share this information with San Juan Regional Medical Center for the purposes stated above. Additionally, by signing this document, I agree to provide a copy of a current PPD (less than 1 yr old), proof of documentation of two MMR vaccines or positive titer, medical documentation of having the chickenpox OR documentation of two Varicella vaccinations OR positive titer, Hep B series or declination, and COVID vaccination or exemption to San Juan Regional Medical Center prior to my clinical start date. I understand that I must provide proof of a current influenza vaccination or declination form between October 1st – March 31st. I understand I will not be allowed to enter the facility for clinical rotations until all requirements have been met.

Signature	Date
Full Name: _____	
<i>Last</i>	<i>First</i> Full Middle Name
Address: _____	
<i>Street Address</i>	<i>Apartment/Unit #</i>
<i>City</i>	<i>State</i> <i>ZIP Code</i>
Phone: (____) _____	Date of Birth: _____
E-Mail Address: _____	
Social Security #: _____	
Name of School: _____	
Degree Sought: _____	
Start Date: _____	End Date: _____

SJRMCM Use Only

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|---|--|---------------------------------------|---|
| ID # : _____ | <input type="checkbox"/> PPD Received | <input type="checkbox"/> MMR verified | <input type="checkbox"/> Varicella verified |
| <input type="checkbox"/> Attended Student | <input type="checkbox"/> Completed Health stream | <input type="checkbox"/> Fingerprints | <input type="checkbox"/> Badge |