PRESBYTERIAN HEALTHCARE
Resident/Student Information Form

Date: _______________

Full Name: ____

Address: ____

Telephone #: ____

Date of Birth: ____

Name of Rotation Group: ____

Rotation Dates: ____

Rotation Facilities *(check facilities where you most likely will be rotating with your supervising physician (s):*

- ☐ Presbyterian Hospital
- ☐ Presbyterian Hospital Huntersville
- ☐ Presbyterian Hospital Matthews
- ☐ Presbyterian Orthopaedic Hospital
- ☐ Presbyterian SameDay Surgery Center
- ☐ SouthPark Surgery Center

Name of Supervising Physician (s): ____

Supervising Physicians Office Address: _____________________________________

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Office Telephone: ____

Status of NC License and # if available: ____________________________________

Medical/Professional School and Graduation Date: ___________________________

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Training Program Attending: ____

Training Completion Date: ____

Malpractice Insurance Carrier: ____