Educational Experience / Department Program Profile & Description Form

Please complete this document in its entirety for consideration

GENERAL			
Name: (Last) (First) (Middle)			Today's Date
Present Address (Street, City, State, Zip Code)		Phone # with Area code:	Are you at least 18 years of age? Yes NO
Have you ever participated in an Education Experience or Department Program at MCW? Yes NO	If yes, indicate dates of the Education Experience/Dept. Program, MCW contact, & Department name:		
Are you a U.S. Citizen or are you authorized to work in the U.S.? Yes NO	If not U.S. citizen, what visa status do you currently hold?	Dates eligible to be in the U.S.:	
Have you ever been employed by the Medical College of Wisconsin? Yes NO	If yes indicate dates, position, and Department:		

Are you currently excluded, debarred or otherwise ineligible to participate in the Medicare, Medicaid or any other Federal health care program or in any Federal procurement or non-procurement programs; or have you been convicted of a criminal offense related to the provision of health care items or services, but have not yet been excluded, debarred or otherwise declared ineligible to par

Participant Signature **Date**

Parent/Guardian signature **Date**
(if participant is under the age of 18)

MCW Department Administrator Signature **Date**

DESCRIPTION OF EXPERIENCE

Department Name: _____

Name of Supervising faculty/staff: _____

Type of Participant (check one): Student Intern For Credit | Student Intern Not for Credit | Observer | Dept. Program Participant

Date range of Experience or Department Program: _____

Experience/Program Schedule: Please indicate the estimated hours the participant will work below.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM (# of hours)	# of hours	# of hours	# of hours	# of hours	# of hours	# of hours	# of hours
PM (# of hours)	# of hours	# of hours	# of hours	# of hours	# of hours	# of hours	# of hours