



W.G. Hefner Medical Center

Affiliating Nursing Instructor/Student Nurse Computer Access Request

Please Print

Name: (Last) (First) (M.I.) (Nickname)

Social Security #: Gender: Date of Birth:

College/University: Business Phone:

Date Rotation Begins: Rotation Ends:

Clinical Location: Clinical Phone Ext.:

Street Address:

Home Phone: Area Code Number

Mailing Address: (if other than Street Address)

In case of emergency contact:

Name Relationship

Area Code Number

Address: