



STUDENT CREDENTIALING FORM

NAME: _____ SSN: _____
 ADDRESS: _____ PHONE: _____
 _____ EMAIL: _____

MEDICAL SCHOOL: _____

EXPECTED YEAR OF GRADUATION: _____

EMERGENCY NOTIFICATION:

NAME: _____ PHONE: _____

ADDRESS: _____

RELATION: _____

I have received information from Plaza Medical Center of Fort Worth regarding policies related to student activities and conduct and agree to abide by those policies. I further certify that the information I have entered on this credentialing form is correct to the best of my knowledge and I will notify Plaza Medical Center of Fort Worth of any changes in a timely manner.

STUDENT SIGNATURE: _____ DATE: _____

PLEASE LIST REQUESTED SERVICES:

_____	_____
INCLUSIVE DATES	SERVICE AND PRECEPTOR (IF KNOWN)
_____	_____
INCLUSIVE DATES	SERVICE AND PRECEPTOR (IF KNOWN)
_____	_____
INCLUSIVE DATES	SERVICE AND PRECEPTOR (IF KNOWN)

PLEASE PROVIDE PLAZA MEDICAL CENTER WITH A LETTER OF GOOD STANDING AND ROTATION APPROVAL FROM YOUR CLERKSHIP DIRECTOR, PROOF OF LIABILITY INSURANCE AND A COPY OF YOUR IMMUNIZATION RECORD BEFORE YOUR FIRST START DATE.

PMCFW DIRECTOR OF MEDICAL EDUCATION