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 participate in any such program? Yes ☐ NO ☐

Have you ever been convicted of any crimes, offenses to include civil forfeiture or fine, or currently subject to pending charges? Yes ☐ NO ☐

If yes, please list all convictions, offenses, or pending charges. Admission to a pending charge, conviction record for a felony, misdemeanor, or ordinance violation does not necessarily disqualify you from participating in the Educational Experience.

EDUCATION

Name of School Attended	Dates Attended	Did you graduate?	Degree Received	Major/Minor or Specialization
High School:				
College:				
Post-Baccalaureate:				
Medical School:				

I certify that the information in this Educational Experience Profile & Description Form is true and complete to the best of my knowledge. I authorize the Medical College of Wisconsin to investigate the information I have provided herein and I hereby release and hold harmless the Medical College of Wisconsin and its representatives, which shall also include affiliated partners Children's Hospital of Wisconsin, Froedtert Memorial Lutheran Hospital and Veterans Affairs, Clement J. Zablocki Medical Center, for their acts performed in connection with investigating the information herein, my background and qualifications. I further authorize any party listed on this Form to release any information they have about me to the Medical College of Wisconsin, and I release those parties and their representatives from any and all liability for providing such information. I understand that approval of my participation in the Educational Experience will be based upon the information gathered in these reference checks, as well as information obtained from a criminal background check. I certify that the information provided by me herein is true, correct and complete without misrepresentation or omission of any kind whatsoever. I understand that if any of the information I've provided in this Form is discovered to be incorrect, false or misleading, or if it contains any misrepresentations or omissions of any kind whatsoever, it will be a basis for immediate cancellation of the Educational Experience. I agree that before or during the Educational Experience, I will immediately notify the Medical College of Wisconsin if at any time (a) I am 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; and/or (b) I am 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 participate in any such program.

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: Click here to enter text.

Name of Supervising faculty/staff: Click here to enter text.

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: Click here to enter text.

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

Please describe the Experience/Program activities and the name of the Department Program, as applicable:

Click here to enter text.