Providence SWEDISH

Student, Resident, Fellow, or Intern Registration

Providence Regional Medical Center Everett

Please check appropriate box: ☐ Student ☐ Resident ☐Fellow ☐Intern/Extern

Name: _____
(Please print first, middle, last name)

Date of Birth: _____ Last 4 Digits of your SSN: **XXX-XX-**_____
(MM/DD/YYYY)

Gender Identity: ☐ Male ☐Female ☐Non-Binary ☐ _____

Email Address: _____ Cell Phone Number:_____

Sponsoring Program or School:_____

Start Date: _____ Expected End Date: _____

Number of expected hours during clinical rotations **(Students or interns ONLY):**_____

Do you currently hold a WA State Professional Practice License? ☐ Yes ☐ No

Please list the type of license and license number:_____

Do you currently hold a Professional Practice License in another state? ☐ Yes ☐ No

Please list the type of license and license number:_____

Area of specialty or practice: _____

Are you currently a Providence Swedish Caregiver ☐ Yes ☐ No

Have you ever worked for or been a student at Providence Swedish or affiliate? ☐ Yes ☐ No

If **yes**, to the above, please provide the following details:

Location: _____ Department: _____ Position: _____

I have read and agree to abide by the policies outlined in the attached information given to me.

Signature: _____ Date:_____

Sponsor Name: _____
(Please print full name)

Sponsor Email: _____ Phone: _____