Regional Health
P.O. Box 6000
Rapid City, SD 57709
regionalhealth.org

Pharmacy Caregivers
Application for Entry to Regional Health

Non-Employee #: (HR Use)_____

All information is required unless noted with an *

LAST NAME (Legal)	**FIRST NAME** (Legal)	**MIDDLE INITIAL**	**SOCIAL SECURITY #:**_____ **DOB:** _____
ADDRESS			**LOCAL PHONE #:** _____ **E-MAIL:** _____
CITY:	**STATE:**	**ZIP:**	

COMPANY / SCHOOL AFFILIATION:

☐ SDSU – College of Pharmacy
☐ Creighton University
☐ University of Wyoming
☐ Other: _____

Company Contact /
Institution Instructor Name: _____
Phone:_____
Graduation Date:_____

POSITION:

☐ Pharm D Student
☐ Pharmacy Tech Student
☐ Current Regional Health Employee Employee ID#: _____
☐ Other: _____

DEPARTMENT: _____

START DATE: _____
END DATE (Annual)**:** _____

REGIONAL HEALTH SPONSOR:

Name: _____
Department:_____Phone:_____

INFORMATION BELOW PROVIDED BY REGIONAL HEALTH SPONSOR

***OTHER INFORMATION:**

Return to your Regional Health Sponsor

Regional Health Sponsor Signature: _____Date: _____

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ROTATIONS FOR PHARMACY CAREGIVERS

LAST NAME (Legal)	**FIRST NAME** (Legal)	**MIDDLE INITIAL**

ROTATION 1

Department: _____

Start Date:_____

End Date: _____

Preceptor Contact: _____

ROTATION 2

Department: _____

Start Date:_____

End Date: _____

Preceptor Contact: _____

ROTATION 3

Department: _____

Start Date:_____

End Date: _____

Preceptor Contact: _____

ROTATION 4

Department: _____

Start Date:_____

End Date: _____

Preceptor Contact: _____

ROTATION 5

Department: _____

Start Date:_____

End Date: _____

Preceptor Contact: _____

ROTATION 6

Department: _____

Start Date:_____

End Date: _____

Preceptor Contact: _____

COMMENTS / NOTES

_____

Return form to: rhmedstaff@regionalhealth.org