



Information Systems Set-up Request (ISSR) for Students and Clinical Instructors

This section to be completed by Student / Instructor

First Name: _____ MI _____ Last Name: _____

If applicable, name on clinical license: _____

SSN: ___ / ___ / ___ Date of Birth: ___ / ___ / ___ (mm/dd/year)

Mother's Maiden Name: _____

Assigned Location: ___ SRMC ___ RRMC ___ TMC

Assigned Unit/Department/Preceptor: _____

Start Date: ___ / ___ / ___ Stop Date: ___ / ___ / ___

This section to be completed by HPHS Clinical Placement Coordinator

Lawson 3-4 ID: _____ (Date requested: ___/___/___)

ID sent to school contact / student _____ (Date Sent: ___ / ___ / ___)