Physical Therapy Program
University of Wisconsin- Madison
STUDENT PERSONAL DATA FORM

Student Name: ____

Address (during the school year): ____________________________________

____

Phone (during the school year): _____________________________________

Cellular phone: ____

E-Mail: ____

Permanent Address: ____

____

Permanent Phone Number: ____________________________________

In Case of Emergency, notify:

Name: ____

Address: ____

Phone: ____

REQUIREMENTS	DATE COMPLETED
CPR Certification or Recertification [dates CPR is current]	
Bloodborne Pathogen Inservice	

Note: 1. The PT program is not permitted to retain health records, therefore, it is the responsibility of the student to retain records and to provide documentation as requested by the clinical facility.

2. The student is responsible for knowing and complying with the requirements of the clinical facility to which they are assigned.

I verify that the above information is true and complete:

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Student Signature Date