Healthcare/Education Partnership Eligibility Form

CHAMBERLAIN UNIVERSITY

Completion of this form is required to receive Healthcare Partnership or Education Partnership benefits for all new and continuing students.

Date: _____

Applicant Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Start Date of Program: _____ Student ID (D#) (if available): _____

Program of Study: _____ Student Status: _____

Employer/Education Partner Information:

Name of Partner (Employer/School/Association): _____

City: _____ State: _____ Zip: _____

Start Date of Employment for Applicant: _____

Graduation Date: _____ Association Member ID Number (Association Partners Only): _____

Preceptor Information:

Have you ever served as a preceptor for Chamberlain University while employed by this Healthcare Partner? ☐ Yes ☐ No

If yes, please provide the most recent dates that you did so: _____

If no, would you be interested in serving as a preceptor for Chamberlain University? ☐ Yes ☐ No

Campus (indicate online if this was for an online course): _____

Applicant states and affirms eligibility to participate in the program as denied by the choice of options contained herein. Applicant further understands and agrees that Chamberlain University may, from time-to-time and at its sole discretion, verify the applicant's continued eligibility. Applicant will furnish such proof as Chamberlain University requests.

Chamberlain Applicant/Student Signature: _____