

Clinical Simulation Center of Las Vegas
**Standardized Patient
Confidential Data Form**

Date: _____

NAME: _____ REFERRED BY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ SSN: _____ - _____ - _____

PHONE : _____ MOBILE: _____ EMAIL: _____

CURRENTLY EMPLOYED? YES NO HOW LONG?

Name of Employer:

CURRENTLY IN SCHOOL? YES NO

Name of School:

EXPERIENCE IN ACTING? *(Please give brief description)*

EXPERIENCE IN TEACHING, TUTORING, COACHING, ETC? *(Please give a brief description)*

PLEASE LIST ANY FORMAL EDUCATION OR TRAINING IN HUMAN COMMUNICATION:

The following information is OPTIONAL, but would help us match you to specific patient scenarios:

DOB: _____ GENDER: Male Female

RACE: (Please Check) African American Asian Hispanic Caucasian American Indian

BODY TYPE: (Please Check) Small Medium Large

SCARS (accidents or surgery): *(Please give brief description)*

CHRONIC HEALTH CONDITIONS (Diabetes, Heart, lung, hearing, vision, orthopedic, etc.):

AVAILABLE: (Please Check) Mornings Afternoon Evenings

Please attach any additional information you would like us to consider for this position:

FOR OFFICE USE ONLY:

SP Start Date _____

Approval _____