Clinical Simulation Center of Las Vegas

Standardized Patient
Confidential Data Form

Date: _______________

FULL LEGAL NAME:___________________________ REFERRED BY: __________________________________

PREFERRED NAME:____

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 ☐

ADDITIONAL LANGUAGE:____

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______________

Revised 9/26/19 gg, msp