Family Care Associates – Student Request Form

Please complete the entire packet and send fax to 217-342-7002.

Today's Date:_____

Name:_____ Specialty:_____
(MD, APRN, Health Occ, etc)

Phone:_____ Anticipated Graduation Date: _____

Email:_____ Referred By: _____

School: _____

Type of rotation (Peds, family medicine, women's health, etc): _____

Dates Requested From:_____ To:_____

Hours Needed _____

Please include a copy of the following up-to-date immunizations:

- Tdap (Mandatory)
- MMR – 2 doses (Mandatory)
- Hepatitis B series (Recommended)
- Seasonal Influenza (Mandatory)
- COVID 19 (Mandatory)

Comments:_____
_____
_____
_____