Date:

**SUPERVISED PRACTICE FACILITY INFORMATION**

Facility Name:

Address:       City:       State:       Zip:

Facility Phone Number:       Facility Fax Number:

Facility’s Contract or Business Officer:

Contract or Business Officer Email:

**Which rotations will be accomplished at this facility (check all that apply):**

**Medical Dietetics (650 hours):**

Clinical Inpatient Long-Term Care Outpatient Critical Care Staff Relief

*Specific disease processes:*Wt mgt and Obesity Diabetes Cancer CVD GI disease Renal

**Food Service Management (250 hours):**

School Acute Care Long-Term Care Rehab Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Community (250 hours):**

WIC Head Start Public Health Wellness School Long-Term Care Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intern’s name and dates assigned to this facility:

Preceptor’s name:

Brief description of facility/agency/institution (mission, population served, etc):

|  |  |  |
| --- | --- | --- |
| Number of Registered Dietitians employed full-time: | | part-time: |
| Number with advanced degree and/or specialized certification: | |  |
| Number of Registered Diet Technicians employed full-time: | | part-time: |
| Typical inpatient/client census: | | Weekly outpatient census: |
| **\*If this practice site/facility will provide a foodservice systems management experience for the intern, please answer the following:** | | | |
| Name of Foodservice Director: | | | |
| Basic type of operation (e.g. cook-chill, conventional, room service, etc.): | | | |
| Number of employees FTE’s: | Number of meals served per day: | | |