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:       |