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|  | **FACILITY FORM** |
| Intern Name:  |  |
| Facility Name: |  |
| Street: |  |
| City, State, Zip |  |
| Website:  |  |
| Printed name of contact for affiliation contract |  |
| Phone:  |  | FAX:  |  |
| Email (print): |  |
| Printed name of person completing this form:  |  |
| Email of person completing this form: |  |
| Phone for person completing this form: |  |
| Which rotation(s) will be done at this facility (mark all that apply below) |
| **Nutrition Therapy**  | **Foodservice** | **Community** | **Business & Entrepreneurship** |
| Type facility:\_\_\_ acute care\_\_\_ skilled nursing / rehab\_\_\_ dialysis\_\_\_ outpatient clinic Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Conditions:**\_\_\_ overweight/obesity\_\_\_ diabetes / endocrine\_\_\_ cancer\_\_\_ malnutrition\_\_\_ cardiovascular \_\_\_ gastrointestinal\_\_\_ renal\_\_\_ respiratory\_\_\_ other \_\_\_\_\_\_\_\_\_\_\_\_\_***Is there a Registered Dietitian available to supervise intern?***\_\_\_ yes \_\_\_ no | Type facility:\_\_\_ school\_\_\_ acute care\_\_\_ rehab / long-term care\_\_\_ other \_\_\_\_\_\_\_\_\_\_**Type operation:**\_\_\_ conventional\_\_\_ cook-chill\_\_\_ room-service\_\_\_ commissary\_\_\_ other:**Number of employees**/FTEs**\_\_\_\_\_\_\_\_\_ meals served daily**(minimum of 60/day) | Type facility: \_\_\_ school\_\_\_ WIC\_\_\_ public health\_\_\_ Coop Extension\_\_\_ SNAP education\_\_\_ Head Start\_\_\_ senior nutrition\_\_\_ employee wellness\_\_\_ outpatient clinicType:  | Type of business: |
| For questions, contact the internship director at KADDI@consultingdietitians.com or 918-574-8598 |