UPMC Pinnacle

AFFILIATING FACULTY INFORMATION FORM

School Year :	DOB: (mm/dd/yyyy)	
Last Name:	First Name:	MI:
Home Phone: ( )	Cell Phone: ( )	
Email:		
Address:		
City:	State:	Zip:
School:		
Clinical Area(s):		
PA RN License Number:	Exp:	PPD Date:

CERTIFICATIONS

Type	Expiration Date
BLS (Required)	
ACLS	
PALS	
NEONATAL RESUSCITATION	
OTHER:	

CLINICAL EXPERIENCE (Begin with most recent)

AREA	POSITION	DATES OF EXPERIENCE

Please complete by typing directly on form - email as an attachment to
cjohnson@pinnaclehealth.org