UPSTATE
UNIVERSITY HEALTH SYSTEM

Student Nurses/Clinical Instructor Epic Training Registration/Verification Form

Last Name	First Name	New or Returning **N** or **R**	Clinical Start/ Return Date	Virtual Epic Training Date & Time	Upstate ID# *(If Known)*	Student or Instructor **S** or **I**	Upstate Employee? *(Current or Past)* **Yes** or **No**	*If New:* Student/Instructor Email Address	Instructors Only: RN License Number