

NAME \_\_\_\_\_ FR SO JR SR

Shifts in order of preference:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

One shift you do not prefer:

1. \_\_\_\_\_

Drugs, foods, or chemicals you are allergic to: \_\_\_\_\_

Illnesses or medications that may affect you: \_\_\_\_\_

Schedule:

*Please list all classes, labs, official practices, work, etc... Be specific; use class titles, organization names, etc.*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8							
9							
10							
11							
12							
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							