



MEDICAL STUDENT / RESIDENT

EPIC TRAINING QUESTIONNAIRE

Name: _____ School: _____

Check one: Med Student Resident PA Student PA Other: _____

What year: 1 2 3 4

Check: Inpatient Emergency Department Physician Office

Do you have experience with the Epic EMR: No Yes (if yes continue)

What setting: Office/Ambulatory Inpatient Both

What facility: _____

Is this a Franciscan Health facility: *No Yes (if yes, continue?)

Date of Epic training: _____

*You must attend Franciscan Alliance Epic training (even if you have attended training at another healthcare facility).

Please return to Sherry.oland@franciscanalliance.org

as soon as possible so your Epic training can be scheduled.