Please Note: The School must submit this form on behalf of their student; student submissions will not be accepted. One request form must be filled out for each rotation a student needs (one provider, one rotation, one request form).

GRADUATE CLINICAL PLACEMENT REQUEST FORM

Date of Request:	
University/College Requesting Placement:	
Name/position of person making this request:	
Affiliation Contract/Agreement Current?	
School Instructor Name **Email:** **Phone:**	**Course Title:** **Course syllabus available upon request*
Student Name (Last, First, Middle Initial):	
Student Type or Degree: (Med student, NP, PA, PT, OT, AT, Pharmacy etc.)	
Student School Email Address:	
Student Level/Semester	Graduation Date:
Name of Healthcare Facility & location:	Unit/Dept:
Is this rotation mandatory for degree completion? **If not, why is the student interested in this area?**	
Is this the student's first rotation with this healthcare facility?	

First Clinical Day:	**Last Clinical Day:**	**Total Clinical Hours for this rotation:**

Has student communicated with someone about potentially serving as their preceptor? If so, list name/location. **(Note: this does not guarantee placement with the preceptor).**
Is the student a current employee of an area healthcare facility? ☐ **Yes -Where:** ☐ **No**
List any requirements/credentials needed of preceptor:

RECEIVING HEALTHCARE FACILITY APPROVAL

☐ **Accept** ☐ **Deny**	☐ **School Notified** **Comments:**
Preceptor TBD ☐	**Preceptor Name:**
Phone:	**Email:**
Contact (name & phone) **if you haven't been notified by** (date)	
Signed by Healthcare Facility Representative:	**Date**