



Fox Valley Health Care Alliance

**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?**

**Course Instructor/Faculty:**

**Course Title:**

**Email:**

*\*Course syllabus available upon request*

**Phone:**

**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 In School/Graduation Date:**

**Name of Healthcare Facility and Department /Unit Requested:**

**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**