



Fox Valley Health Care Alliance

**UNDERGRADUATE CLINICAL PLACEMENT REQUEST FORM**

**Date of Request:**

**Healthcare Facility / Department or Unit Requested:**

**Contract/Agreement Current?**

**Comments:**

**School Requesting Placement:**

- FVTC
- UWO
- NWTC

- MPTC
- Marian University
- Other:

**Name of Requestor Course /Coordinator:**

**Course Instructor:**

**Course Title:**

Email:

Email:

Phone:

Phone:

*\*Course syllabus available upon request*

**Nursing:**

BSN

ADN

LPN

CNA

Other

**Allied Health:**

PT

PTA

OT

OTA

ST

SW

RT

Phlebotomy

MA

Med Tech

Surgical Tech

Dietician

EMT

Paramedic

Pharmacy

**Medical Imaging:**

X-ray tech

Ultrasound

Mammography

Radiation oncology

MRI tech

Nuclear medicine

**Other:**

Athletic Training

Biomedical Engineering

Healthcare Administration

Medical Records / Transcription

Other

**STUDENT LEVEL/SEMESTER IN SCHOOL OR COURSE DESCRIPTION** (Please check all that apply)

- Interim
- Sophomore
- Junior I
- Junior II
- Senior I
- Senior II

- Semester  1  2  3  4
- Accelerated: (indicate level)
- On-site preceptor needed
- Clinical instructor present
- Quality project only, mentor/advisor name if known \_\_\_\_\_

Comments:

**If preceptor is required, are there special requirements or specific licensure needed?**

**Number of Students:**

**Total Clinical Hours:**

**Days of Week:**

**Student Name (only if 1:1 placement):**

**Time of Day or Shift:**

**First Clinical Day:**

**Last Clinical Day:**

**RECEIVING FACILITY APPROVAL**

Accept

Deny

School Notified

**Comments:**

**Preceptor TBD**

**Preceptor Name:**

**Email:**

**Phone:**

**Contact**

(name & phone) **if you haven't been notified by**

(date)

**Signed by Facility Representative:**

**Date**