UNDERGRADUATE - CLINICAL PLACEMENT REQUEST FORM - INSTRUCTIONS FOR COMPLETION

PURPOSE: The purpose of this form is to provide a consistent format for requesting student placements among FVHCA facility members and facilitate planning between member schools and facilities.

FACILITY / LOCATION REQUESTED

- Indicate the facility you wish to place students. Some health care organizations have several facilities; please specify the exact location of the facility you are requesting.
- Indicate specific department within the facility you are requesting placement.
- Identify the facility contact person with whom you may be coordinating placement with; some facilities may have more than one. Include contact information.
- Does an agreement/contract exist between facility and school? If it is an ongoing agreement, then indicate *"ongoing".*

  NOTE: If no agreement or contract exists, please indicate this here by saying "no" and further explain under *"comments".* **An agreement or contract needs to exist prior to student placement**; please contact your school representative for assistance in obtaining one.
- Indicate the year and semester the student will be at the facility.
- Identify the preferred patient population for student clinical experiences (pediatric, adult, acute care, long term care, home care, etc.).

SCHOOL REQUESTING PLACEMENT

Identify the school making the request. If school is not listed, please check "other" and specify.

COURSE COORDINATOR / REQUESTOR

- Identify the course coordinator and/or instructor (where applicable); and provide contact information. This information is vital in the event a situation should occur requiring notification of the school.
- Indicate the course title: (adult health, the chronically ill patient, second semester clinical, etc.)

TYPE OF STUDENT OR STUDENT PROFILE

- Please check the type of student that will be placed at the facility. If an appropriate selection is not listed, check *"Other"* and define.
- Student Level: Identify the student(s) level in school; check all that apply. For 1-2 year programs, indicate the semester. **Please identify if on-site preceptor needed or clinical instructor is present.**
  Use the "Comments" to provide a brief synopsis or purpose of the clinical.

NUMBER OF STUDENTS – (*Identify the following:*)

- Number of students
- Number of clinical hours needed
- Days of the week (if precepted student, may indicate *"scheduled with preceptor"* or days student is available)
- Shift or time of day (if precepted, indicate preference or "no preference")
- First and last clinical day expected

SUBMIT - save the form & send to the appropriate facility contact person via fax or email for approval.

RECEIVING FACILITY APPROVAL

Facilities will attempt to complete the approval section and return it approximately four weeks before the clinical start date whenever possible.

"Comments" may include clinical department contact information, reasons not approved or other special conditions that need to be communicated. "Facility representative" is the approving agent for the facility.

Updated July 2015