Black River Health

CLINICAL ROTATION SITE REQUEST

Date: _____

Name: _____ **Phone:** _____

Address: _____

Email: _____

Name of School: _____

Address: _____

Administrative Contact Name: _____ **Phone:** _____

Address: _____

Email: _____

Program

- ☐ CRNA
- ☐ Dietitian
- ☐ Master's Prepared Nurse
- ☐ Medical Lab Tech or Lab Tech (AD or BS)
- ☐ Medical Student
- ☐ Nurse Practitioner
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Physician Assistant
- ☐ Radiology
- ☐ Registered Nurse (ADN/BSN)
- ☐ Respiratory Therapy
- ☐ Social Services
- ☐ Speech Therapy

Projected Dates of Rotation: _____ **to** _____

Number of hours/week desired: _____ **Number of completion hours required:** _____

Practice Setting Desired:

- ☐ Emergency
- ☐ Inpatient/Acute Care
- ☐ Outpatient/Clinic
- ☐ Surgery

Responsibilities of Preceptor (attach copy of syllabus with completed form) _____

_____

_____

Minimum Qualifications of Preceptor Required: _____

Has a preceptor already agreed to accept student? ☐ Yes ☐ No

If Yes, Name of Preceptor _____ **Phone:** _____

Student Experience Desired:

- ☐ Documentation in EMR,
- ☐ Assist with/perform clinical procedure
- ☐ Rounds
- ☐ Medical histories
- ☐ Physical exams
- ☐ Use of equipment
- ☐ Assist in surgery
- ☐ Other: _____

Does the school have a current affiliation agreement with BRH? ☐ Yes ☐ No ☐ Unknown