REQUEST FOR SPECIALTY CLINICAL PRACTICE HOURS

The student must complete this form and send to their Program Director for signature, and then obtain a final signature from the SON Director. After all signatures are obtained, the student must return the signed document to the Practicum Coordinator.

**It is the responsibility of the student to obtain all signatures and return to Practicum Coordinator for posting.*

Student Name: _____ CWID: _____

Semester: _____ (ex. Spring 2022) Course ID: _____ (ex. NURSG930W54)

Course Name: _____ (ex. DNP ADVANCED PRACTICUM I)

Practicum Site/Facility Name: _____

Practicum Site/Facility Setting Type: _____

Do we have a current Active Affiliation Agreement with this Site? Yes ☐ No ☐

Preceptor - Name: _____ Preceptor - Position: _____

Preceptor - Major Role Functions: _____

# of Clinical Hours Requesting: _____

Rationale for Request:

Student Signature: _____ Date: _____

_____FOR OFFICE USE ONLY_____

Program Director Approval: _____ Date: _____

Director - School of Nursing Approval: _____ Date: _____