



Student Clinical Placement Tracking

From day one.

Please submit one form for each instructor or student group to the Education Department after you have obtained the Clinical Manager or designee's signature.

Educational Institution (School): _____

Discipline (e.g. Nursing, PT, Speech, Pharmacy) _____

Instructor's name: _____

Contact information: Phone _____ **Pager** _____ **Email** _____

Requested clinical rotation site: _____

Start date _____ **End date** _____

Year: 1st _____ 2nd _____ 3rd _____ 4th _____

| <i>Semester:</i> | <i>Number of Students</i> | <i>Clinical Day(s) Circle</i> | <i>Total Student Hours</i> |
|--------------------|---------------------------|-------------------------------|----------------------------|
| Spring 2021 | _____ | M T W TH F | _____ |
| Summer 2021 | _____ | M T W TH F | _____ |
| Fall 2021 | _____ | M T W TH F | _____ |
| OTHER | _____ | M T W TH F | _____ |

CMC Unit Director/Manager:

I have approved this clinical placement request. _____

(Signature)