HEALTH FIRST CENTER FOR LEARNING
CLINICAL/PRACTICUM REQUEST FORM

SCHOOL_________________________________**PROGRAM (EX:ADN)**__________________________

CLASS (EX: 2ND YEAR)_______________________________

INSTRUCTOR'S NAME_______________________________

PHONE # ________________________

PAGER # ________________________

E-MAIL ADDRESS: ________________________________

CLINICAL START DATE ___________ **CLINICAL END DATE** _____________

DAYS OF WEEK (EX: TUES/WED): ____

HOURS DESIRED (EX: 0700-1300): ____

MAXIMUM NUMBER OF STUDENTS ON SITE AT ANY TIME : ______________

SITE REQUESTED(X):

CCH ____		HRMC____		PBCH ____	
CLINICAL EXPERIENCE	OBSERVATION	CLINICAL EXPERIENCE	OBSERVATION	CLINICAL EXPERIENCE	OBSERVATION
MED/SURG____ OB ____ PEDS ____ ER ____	OR ____ OB ____ PEDS ____ ER ____ GI LAB ____ TELE ____ ICU ____	MED/SURG____ OB ____ PEDS ____ ER ____ PCU ____	OR ____ OB ____ PEDS ____ ER ____ GI LAB ____ MICU ____ SICU ____ CATH LAB ____ CCU ____ DIALYSIS ____	MED/SURG____ PCU ____ ER ____	OR ____ ER ____ ICU ____
HOPE____		HOSPICE____		OTHER(SPECIFY): ____________________________	

PLEASE SEND REQUESTS TO:

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HEALTH FIRST CENTER FOR LEARNING
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MELBOURNE, FL 32935
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