

CLINICAL STUDENT REQUEST FORM

COVER LETTER & CHECK LIST

ATTENTION: BWHC STUDENT COORDINATOR

IN REFERENCE TO THE FOLLOWING CLINICAL STUDENT:

STUDENT NAME: _____

SCHOOL: _____

STUDENT CATEGORY/TYPE: _____

ROTATION START/END DATES: _____

CLINICAL ROTATION/DEPT: _____

Attached please find the following completed forms:

Clinical Student POI Form – School section completed and signed

Partners Confidentiality Form – Signed

Copy of Government Issued Photo ID

For questions regarding the information provided, please contact:

SCHOOL COORDINATOR: _____

EMAIL: _____

or

PHONE NUMBER: _____