

INDIVIDUAL STUDENT CLINICAL ROTATION REQUEST

Name of Applicant: _____ Date: _____

Address: _____

Telephone: Home #: _____ Cell #: _____

E-Mail Address: _____

Name of Affiliated School : _____

School Point of Contact: Name: _____ Phone #: _____

E-Mail: _____

Type: Discipline: _____ Undergraduate Year _____ Graduate Year _____

Purpose of clinical rotation: _____

Dates for Rotation:

Beginning: _____ Ending: _____ Total Hours Required: _____

Desired Clinical Rotation Location:

<input type="checkbox"/> Med/Surgical (4A)	<input type="checkbox"/> Long Term Care
<input type="checkbox"/> ICU (4C)	<input type="checkbox"/> OR/PACU
<input type="checkbox"/> ER	<input type="checkbox"/> Primary Care
<input type="checkbox"/> Intermediate Care (5C)	<input type="checkbox"/> Other _____

Will you need access to the (EMR) electronic medical record? Yes No

If yes, what functions do you need? EMR/view only EMR/write notes Medication administration (BCMA) *Students must be accompanied by Affiliate Clinical Instructor during medication administration*

Are you a VA employee? No Yes (If yes, what department?) _____

Title of Desired Mentor/Preceptor _____
 BSN Masters MSN Other _____

I have attached my goals and objectives for this clinical rotation request.

PRECEPTOR/MENTOR:

_____ I understand the Education office is the first point of contact for coordinating student clinical rotations.

_____ I will communicate with the Education office, the student, and the academic instructor at least 3 weeks prior to the student beginning the rotation.

_____ I have received and reviewed MCM 14-12 and understand the requirements for overseeing documentation by students in the electronic medical record.

_____ I have reviewed Appendix C of MCM 14-12 and understand I will complete a mid-term and final evaluation and submit a copy to the Affiliations Coordinator in the Education Office (below):

_____ Proposed date for mid-term review of progress

_____ Proposed Final Evaluation

_____ I understand as a preceptor/mentor that I am directly responsible for the supervision of this student during clinical training.

_____ I understand I cannot precept/mentor a student in my assigned department.

_____ I understand that if I am also employed as an instructor by an affiliated school, I cannot precept/mentor a student from that school.

_____ I understand that employees are prohibited from receiving anything other than their Federal salary as compensation for services as a Government employee. Generally, an employee shall not, directly or indirectly, solicit or accept a gift.

_____ Date: _____

SIGNATURE OF PRECEPTOR/MENTOR

_____ Date: _____

SIGNATURE OF PRCEPTOR/MENTOR'S SUPERVISOR

_____ Date: _____

SIGNATURE OF APPLICANT

_____ Date: _____

SIGNATURE OF CHIEF/EDUCATION LEARNING RESOURCE SECTION

For Education Office Use Only below this line

Is there an affiliation agreement in place with the above named school? Yes No

Is the Internship approved? Yes No

April Engelbrecht, MPA
Affiliation Coordinator
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Martinsburg, WV 25405
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