

# Individual Health Trainee Clinical Rotation Request

Please complete 1 request form per rotation desired

**Applicant Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Name of Affiliated School:** \_\_\_\_\_

School Point of Contact: **Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

Are you a VA employee? \_\_\_\_\_ NO \_\_\_\_\_ YES

(If yes, what department?) \_\_\_\_\_

**Type of Student:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Year in School:** \_\_\_\_\_

**Projected year to Graduate:** \_\_\_\_\_

**Desired Clinical Placement Location:** \_\_\_\_\_

**If other areas please designate:** \_\_\_\_\_

**Anticipated Health Trainee clinical assignments/activities: Goals and Objectives of the rotation** (brief description only and attach course syllabus/rotation requirements):

**Dates for Rotation:**

**Beginning:** \_\_\_\_\_ **Ending:** \_\_\_\_\_

**Shifts available and hours available:** \_\_\_\_\_

**Total Hours required to complete rotation:** \_\_\_\_\_

- I have reviewed the course objectives/syllabus and am willing to accept the above individual for his/her clinical rotation.**

**X**

---

Preceptor/Mentor

**X**

---

Preceptor/Mentor's Supervisor