

**REQUEST FOR NEW OR REVIVAL OF DORMANT CLINICAL SITE**

Date of Request: \_\_\_\_\_

For Internship: \_\_\_\_\_ 2wk. \_\_\_\_\_ 6 wk \_\_\_\_\_ 10 wk \_\_\_\_\_ 1<sup>st</sup> 8 wk \_\_\_\_\_ 2<sup>nd</sup> 8 wk

Name of Student: \_\_\_\_\_

Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Contact Person at Facility: \_\_\_\_\_

Title of Contact Person: (ie.- CCCE, Director of Rehab, Hospital Administrator)

\_\_\_\_\_

Contact Information for Contact Person:

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

Fax #: \_\_\_\_\_

Email address: \_\_\_\_\_

Type of clinical rotation requesting? ( ie acute, pediatric outpatient, outpatient ortho)

\_\_\_\_\_

Will you need housing while at this facility? \_\_\_\_\_ yes \_\_\_\_\_ no

Is this facility willing to take other USA students in addition to you or in the future after you?

\_\_\_\_\_ yes \_\_\_\_\_ no

Why do you want to go to this facility? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_