

Preceptorship Request Form

Children's of Alabama

please Complete each field below

School:		
Director:	PHONE # :	()
Coordinator:	PHONE# :	()
Instructor:	PHONE# :	()
Name of Course:	# of Hours:	

Dates of Clinical Rotations (start and end dates):

Student's Name (last 4	ID#	UNIT		
	(last 4 of SS#)	1st Choice	2nd Choice	3rd Choice