Alternative Clinical Experience Request Form

Directions: Complete the following form **the semester before** the alternative experience, obtain signatures, and submit the form to:

Student Name	
Course	
Semester/Year	
Type of Experience	
Location	
Contact Person	**Name:** **Address:** **Phone number:** **E-mail:**
Preceptor	**Name:** **Address:** **Phone Number:** **E-mail:**
Clinical Experiences	
Number of Hours	

	Name	**Signature**	**Approve Yes/No**	**Date**
Course Coordinator				
Program Coordinator				
PIC Professional Graduate Programs				

Approved 4/26/2010