

ANDREWS UNIVERSITY

Department of Physical Therapy

CLINICAL EXPERIENCE SPECIAL REQUEST

Request for (Practicum or Affiliation #) _____ Date (of clinical) _____

Facility: _____ Phone # _____

Address: _____

Center Coordinator: _____

(If no Center Coordinator, then write in Director's name)

Requesting for: (list 1st, 2nd, 3rd choice) Whatever available _____ Patient Type _____

Outpatient _____ Inpatient _____

Are you prepared to take this facility if housing is not provided (Circle) Yes No

I understand that if this facility agrees to take me I will be required to go!
I understand if housing is not provided or becomes unavailable I will be required to go!

Student Name: _____

Phone # _____

Email _____

Student Signature: _____

Date _____