UTRGV
UT Health Rio Grande Valley
School of Nursing

Name: _____
Student ID _____ **Faculty**
Email: _____
Date: _____
Request for: _____

- ☐ **BSN**
- ☐ **MSN/ADM**
- ☐ **MSN/ED**
- ☐ **FNP**
- ☐ **PMHNP**
- ☐ **DNP**

Clinical Request Form

Directions: Please complete all applicable sections. If a section doesn't apply to you, type n/a.

1. Facility Name _____
2. Facility Type & Services _____
3. Mailing Address _____
4. Physical Address _____
5. Telephone No. _____
6. Contact Person _____ Email _____
7. Individual responsible for approving agreement for facility:
   Name _____ Title _____
   (if different from above)
   Email address _____
8. Preceptor Name: _____ Email _____
   Telephone No: _____
9. Does facility have multiple sites which should be included in the agreement?
   Yes ◯ No ◯

   _____

   _____
10. Were clinical objectives shared ◯ Yes ◯ No (not at this time)

If, yes, please list on page 2. The student will present course objectives when the agreement is authorized, and clinical practice may begin. Each course has different objectives; however, the clinical practice expected is for patients across the lifespan.

11. Initiating Faculty _____ Telephone _____
    Email _____
12. Department/Program _____

Clinical Objectives
