UTRGV
UT Health Rio Grande Valley
School of Nursing

Student Name: _____
Student ID: _____
Student Email: _____
Date: _____
Semester: _____
Course # (NURS): _____
Course Instructor: _____

Program: ☐ **FNP** ☐ **PMHNP** ☐ **DNP**

Clinical Request Form

Directions: **Please complete all applicable sections. If a section doesn't apply to you, type N/A. Form must be typed with every line completed for accuracy and to avoid delays. No handwritten forms will be accepted.**

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 (if different from above):

   Name: _____ Title: _____

   Email address: _____
8. Preceptor Name: _____ Email: _____

   Telephone No: _____

   Collaborating Physician (For APRNs): _____
9. Does facility have multiple sites which should be included in the agreement?

   Yes ☐ No ☐ If yes, please list other sites below:

   _____

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

    If, yes, please list Clinical Objectives below:

    _____

    _____

    _____
11. Initiating Faculty: _____ Telephone: _____

    Initiating Faculty Email: _____