2500 North State Street
Jackson, MS 39216-4505
(601) 984-6255 ● (601) 984-6211

NEW CLINIC REQUEST FORM

STUDENT NAME: ____

PRECEPTOR/FACILITATOR NAME: ________________________________

DATE: ____

I am requesting a CLINICAL EDUCATION PLACEMENT AGREEMENT be initiated with the agency listed below.

1. AGENCY NAME: ____

2. AGENCY ADDRESS: ____

CITY/STATE/ZIP: ____

AUTHORIZED OFFICIAL IN BUSINESS OFFICE: (The preceptor is not the authorized official)

3. NAME:____

4. EMAIL ADDRESS: ____

5. PHONE:________________________FAX:________________________

S.O.N. APPROVAL: ____

SEMESTER: COURSE NUMBER: ________________

Summer (June–August) [ ]
Fall (August–December) [ ]
Spring (January–May) [ ]

ACADEMIC YEAR: _______

New Clinic Request Form: March 2016
Revised: Nov. 2017; Jan 2018; Feb 2018; Mar 2018; Aug 2018