Department of Radiologic Technology
EXTERNAL CLINICAL ASSIGNMENT REQUEST

Please complete the following information and return to your Program Director

1. **Your name and major:_____**
2. **Institution/site, address, phone number and fax number of proposed external clinical assignment.**

   Phone #_____ Fax #_____
3. **Name, title and credentials (ARRT, ARDMS, M.D., etc.) of the following:**
   a. **Clinical Supervisor who administers the proposed clinical education site.**
   b. **Clinical Instructor who will provide clinical evaluation.**
   c. **Director of unit to whom correspondence is to be sent.**
4. **Reason for request:**
5. **Projected clinical education (hours, days):**
6. **Projected starting date:**

Student signature_____ Date_____

Program Director comments and signature_____

Approve_____Disapprove_____Date_____

Department Chair Signature:_____

<u>This section to be completed by Department</u>

Does an affiliation agreement exist for this institution. Yes_____ No_____

If no, prepare one-time agreement letter.

Letter returned _____Student notified_____