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:______________________________________

This section to be completed by Department

Does an affiliation agreement exist for this institution.  Yes_______  No_______

If no, prepare one-time agreement letter.

Letter returned _____________Student notified_____________