4-April-22

SLBMC Clinical Education Request Form
Clinical Rotation/Observership

PERSONAL INFORMATION (IN BLOCK LETTERS)

Name _____
Last Name *First Name* *Middle initial*

Home Address _____
Street *City*

_____
State *Country* *Zip*

Main Contact # _____ E-mail _____

Home University (Name of Institution) _____

Student Affairs/Main Contact # _____ E-mail _____

Level/Year of Study _____

Next of Kin _____
Last Name *First Name*

Main Contact # _____ E-mail _____

I would like to apply for: Clinical Rotation ☐ Observership ☐

START DATE: [dd/mm/yyyy] _____ ____(weeks)

PREFERRED SPECIALTIES:

1. _____ ____ (weeks)
2. _____ ____ (weeks)
3. _____ ____ (weeks)
4. _____ ____ (weeks)
5. (OTHER) _____ ____ (weeks)

STUDENT UNDERTAKING:

I confirm that I have read and understood the terms and conditions as stipulated in the information provided. I accept that the Sir Lester Bird Medical Centre reserve the right to withdraw my application if these conditions are not satisfied. I am aware that the information submitted above can be used by authorized personnel within SLBMC but will not be passed on to any other individuals or entities.

*****Please submit this request form with the required documents as a single file.**

_____
Applicant Signature