Experiential Learning Request Form

□ **Shadower (less than one 8-hour day)**
□ **Observer (more than one 8-hour day)**
□ **Clinical Experience (seeking credit as part of program)**
□ **Non-Clinical Experience (seeking credit as part of program)**

APPLICANT INFORMATION:

Name _____ Phone _____

Address _____ City _____ Zip _____

Age ____ Birth Date _____ E-mail _____

SCHOOL INFORMATION (if seeking credit):

School Name: _____

School Contact: _____ Email: _____

EXPERIENTIAL REQUEST:

Practice Location Requested _____

Start Date _____ End Date _____
Day(s) please circle M, T, W, TH, F Start Time _____ End Time _____

(Shadower: enter one date for start and end)
(Observer: enter span of no more than 4 weeks; 3 days per week maximum)
(Clinical or non-clinical experience – seeking credit: require agreement with school specifying start and end dates of scheduled experience)

Please return completed form to learningexperience@unityhealthnetwork.org**.**
Allow up to 10 business days from receipt of all requested forms/documentation for processing.

FOR UHN COMPLETION ONLY

Location _____

Supervisor _____

Schedule _____

☐ **Request Form**

☐ **Signed Guidelines**
☐ **Consent/Waiver**
☐ **Immunizations**
- **2-Step TB Test**
- **Flu Documentation**
- **MMR**
- **Varicella**
- **Hep B**
- **COVID-19**

☐ **Entered in log**
_____ **Status Email**
_____ **Approval Email**
☐ **eCW Security Needed**