Affiliated School Clinical Request Form

School:	**Date Submitted:**
Program:	**Semester/Year:**
# Clinicals Requesting:	*Please put **Start** and **End** *Dates* of clinicals below, as well as **Start** and **End** *Times* of clinicals

Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM Shift **Acute Care (Medical-Surgical)**							
PM Shift **Acute Care (Medical-Surgical)**							

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Unit	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
OB							
OB							
OB							
OB							

Form will automatically go to student.nurse@woodcountyhospital.org