AZSA-AcademicAffiliations@DignityHealth.org

Clinical Student Request

Thank you for your interest in Dignity Health. In order for us to complete your request, we need the following information. Once complete, please save and email to the above address.

mCE Request#: _____

School: _____ Program/Student Type: _____

Name of Student: _____ Student is a Dignity Health Employee? ☐ Yes ☐ No

Student Email: _____ Student Phone: _____

Name of Instructor: _____ Instructor Email: _____ Instructor Phone: _____

Name of School Coordinator: _____ Coordinator Email: _____ Coordinator Phone: _____

Type of Experience: _____ Department/Unit Contact: _____

Name of Preceptor: _____ Position: _____

Total Hours Requested: _____ Shift/Hours: SELECT Facility Requested: Dignity Health Medical Group

Days of the Week Requested:

Dates Requested (Dates x Hours must equal Total Hours Requested)

[NOTE: dates must be specific/detailed, not flexible, in order to approve.]

Please add comments as needed.