**ADDENDUM A**

Requests should be sent at least ***6 weeks*** prior to the student’s clinical rotation start date.

Please send completed request to [EducationalAgreements@bcm.edu](mailto:EducationalAgreements@bcm.edu).

**Student information**

(**Note**: Ink requests will ***not*** be accepted. Do ***not*** abbreviate)

Student Name:

School:

Program of Study:

**Preceptor Information**

(**Note**: Ink requests will ***not*** be accepted. Do ***not*** abbreviate)

Preceptor Name:

Specialty/Department:

Training Location address:

Placement Dates:

Hours Requested:

Name of Employer:

Has the students request been accepted by the Preceptor?

Do the dates requested impact BCM learners in your specialty/department?

Preceptor’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approved by BCM:**

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: Todd A. Reinhart, Sc.D.

Title: Dean, School of Health Professions

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_