**APPENDIX PP**

*REQUEST FOR INDEPENDENT STUDENT PRACTICUM / CLINICAL*

Are you an employee of Sibley (Yes / No) (circle one)

Do you have a JHED ID (Yes / No) (circle one) – if yes, please do not request a new JHID; if no, please fill out appendix JHED ID REQUEST FORM and email to : [SMH-NursingStudents@jhmi.edu](mailto:SMH-NursingStudents@jhmi.edu)

If YES to JHID question; please print JHID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program type (Undergraduate, Masters, Doctoral, other) (Circle one)

Clinical Area/Specialty/Department:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT INFORMATION:

Name of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of preceptor (if known): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Required for masters, doctoral students only)

Dates of experience (from XX to YY & Total # of hours of experience: \_\_\_\_\_\_\_\_\_\_to \_\_\_\_\_\_\_ /\_\_\_\_\_\_

SCHOOL FACULTY INFORMATION:

Name and title of Clinical School Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coord phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coord. Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and title of school faculty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Faculty work phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Three weeks prior to beginning the experience, students are required to submit the following:

1. This request form - completed.

2. Copy of student's professional liability insurance, if the school has not submitted evidence of COI group coverage.

3. All requirements noted in attachment A & AP.

4. Course Syllabus & typewritten copy of student objectives for the experience

9. Copy of RN license for DC (Required for graduate/doctoral students only; Out-of-state license accepted if student will perform no direct patient care activities.)