Clinical Rotation Request

Submit to OLHS.students@ochsnerlsuhs.org
Requests must be completed and submitted electronically. Handwritten requests will not be accepted.

Date of Request: _____

School Name: _____ **Program:** _____

School Contact submitting request: _____ **Phone Number:** _____

School Email: _____ **Semester/Quarter:** Select

Requested Campus/Clinic: Select **Number of Students:** _____

Requested Unit/Department: _____

Rotation START DATE: _____ **Rotation END DATE:** _____

Schedule	Start Time	End Time
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		
☐ Saturday		
☐ Sunday		

Total Number of Day/Hours requested for rotation:

Total: _____ Select

Please provide any details if students will be rotating in any way throughout the semester:

Name of instructor who will be present on the unit: _____

Instructor Email: _____ **Instructor Cell:** _____

Name of Preceptor (if applicable): _____

Preceptor Email: _____ **Preceptor Phone:** _____