WESTERN RESERVE HOSPITAL
Proudly Physician Owned

Experiential Learning Request Form

□ **Shadower (less than one 8-hour day)**
□ **Observer (more than one 8-hour day)**
□ **Clinical Experience (seeking credit as part of program)**
□ **Non-Clinical Experience (seeking credit as part of program)**

APPLICANT INFORMATION:

Name _____ Phone _____

Address _____ City _____ Zip _____

Age ____ Birth Date _____ E-mail _____

SCHOOL INFORMATION (if seeking credit):

School Name: _____

School Contact: _____ Email: _____

EXPERIENTIAL REQUEST:

Department Requested _____

Start Date _____ End Date _____
Day(s) please circle M, T, W, TH, F Start Time _____ End Time _____

(Shadower: enter one date for start and end)
(Observer: enter span of no more than 4 weeks; 3 days per week maximum)
(Clinical or non-clinical experience – seeking credit: require agreement with school specifying start and end dates of scheduled experience)

Please return completed form to explearning@westernreservehospital.org.
Allow 10 business days for processing.

FOR HOSPITAL COMPLETION ONLY

Department _____

Supervisor _____

Schedule _____

- ☐ **Request Form**
- ☐ **Signed Guidelines**
- ☐ **Consent/Waiver**
- ☐ **Immunizations**
  - o **2-Step TB Test**
  - o **Flu Documentation**
  - o **MMR**
- ☐ **Entered in log**

_____ **Status Email**
_____ **Approval Email**