



**REQUEST TO PERFORM A CLINICAL EXPERIENCE OR RESEARCH  
ON SUMMER, VACATION OR ANY APPROVED EXTRACURRICULAR EVENT**

Student's name		Program
Institution* where you will perform the clinical experience or research:		
Supervisor's name:		
Task <input type="checkbox"/> Clinical Experience		<input type="checkbox"/> Investigation
<input type="checkbox"/> Other: _____		
Physical Address		
Postal Address		
Telephone	Email	
Beginning date	Ending date	

**\*Important Note:** Submit an acceptance letter from Supervisor or Institution where you are going to perform this activity.

\_\_\_\_\_ Date \_\_\_\_\_

Student Signature



**FOR INSTITUCIONAL USE**

Approve by: \_\_\_\_\_

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

Insurance: \_\_\_\_\_

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