Request for Kaiser Clinical Rotation

Woodland Hills Medical Center
5601 De Soto Avenue; Woodland Hills, CA 91365
Office (818) 719-4023 Fax (818) 719-2880

Date Clinical Request submitted to Woodland Hills Academic Liaison: _____
Name of school: _____
School contact person: _____ Phone: _____
Email: _____
Semester: ❒ Spring ❒ Summer ❒ Fall ❒ Winter Year: _____

❒**Syllabus <u>MUST</u> be submitted with request**

Designated school instructor: _____ Email: _____
Work phone: _____ Cell Phone: _____
Will school instructor visit the Kaiser Woodland Hills campus during the clinical rotation?
❒ Yes ❒ No

Student category: ❒ NP ❒ MSN ❒ MN ❒ BSN ❒ ADN ❒ LVN ❒ MA
❒ Other _____
Focus of Rotation (course title): _____
Unit/Area Requested: _____
Clinical Rotation Dates From: _____ To: _____
Total Clinical Hours Requested: _____
Clinical days requested: ❒ Mon ❒ Tue ❒ Wed ❒ Thur ❒ Fri ❒ Sat ❒ Sun
Degree requirements of preceptor (if applicable): _____

❒ **<u>Individual Student</u>**
Student name (*Last, First, Middle*): _____
Computer access needed: ❒ Yes* ❒ No

❒ **<u>Student Cohort</u>**
Total number of students in cohort: _____
Computer access needed: ❒ Yes* ❒ No

*If yes, submit the NUID & HealthConnect Access Request Form at least 4 weeks prior to requested start date.

For Staff Education Office use only

❒ **Request granted****
❒ **Request denied**

Current contract with Kaiser Permanente? ❒ **Yes** ❒ **No**

Date _____ **Signature** _____

**Failure to submit NUID & HealthConnect Access Request Form at least 4 weeks before requested start date and all pre-clinical clearance forms 2 weeks prior to requested start date will result in request being denied, even if initially granted.

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