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Professional Experience Placement Details

This form is to be submitted to the Professional Practice Coordinator as soon as you have discussed your placement with the proposed Supervisor, in order for all documentation to be processed and arrangements made.

Student Name: _____ Student #: _____

EHR117 or EHR320 Autumn Session _____ or Spring Session _____
(circle appropriate subject and advise session)

Student Postal Address: _____

Your Tel.: _____ Mobile #: _____
* * * * *

Supervisor Name and Title: _____

Agency Name: _____

Agency Address: _____

Telephone #: _____ Facsimile #: _____

Dates of Placement: _____

Duration of Placement: 120 hours or Other: _____

Student Signature: _____