



☐ TRAVEL DUE TO CLINICAL ROTATION/INTERNSHIP - experience must be required for current degree program and occur 15 miles or more away from student's current address		• Documentation by your program department and • Required for Course # _____
Student's beginning address (full address, city, state & zip): <i>(attach proof of residency)</i>	Clinical site address (name of clinic or hospital, full address, city, state & zip): <i>(attach letter of approval)</i>	
Start date of clinical rotation:	End date of clinical rotation:	
Schedule of rotation <i>(list days and hours—attach separate sheet or agreement)</i> _____ number of round trips to Site #1		

OR

☐ HOUSING DURING CLINICAL ROTATION (full address, city, state & zip): <i>(attach proof of residency)</i> _____ number of months x \$ _____ monthly rent	• Copy of current housing arrangement (mortgage statement or lease) in student's name (primary residence) and • Copy of lodging agreement (rental agreement, hotel bill) in student's name (secondary)
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By signing below,

- I acknowledge that I have attached all supporting documentation and that all information submitted is accurate and true to the best of my knowledge.
- I understand that I may be asked for additional information or my request can be partially or completely denied.
- I understand that if this form is incomplete or lacks the required documentation, no action will be taken.
- I understand this request is for one semester and I will need to reapply each semester that my situation warrants.
- I understand that submitting this form does not guarantee that my request will be granted.

 Student's Physical Signature *(electronic/typed signatures not accepted)*

 Date