EDUCATION EXPERIENCE REQUEST*

Please complete and submit to the Medical Radiography Program via email, fax or mail.

At Valley Health we recognize the value of learning experiences and are committed to working with you to achieve your learning objectives. The required documentation is kept confidential and is filed for tracking, processing, and reporting purposes only.

Date of Request:_____ **Requestor Name:** _____
(Last, First, Middle Initial

Requestor Date of Birth:_____ **Age:**_____
(If ≤ 18 y.o.)

Type of Education Experience *(check one)* ☐ Observation/Administrative ☐ Direct care/Hands-on

Health Profession(s) of Interest_____ **Unit/Program/Specialty Requested**_____
School/Academic Institution (if applicable) _____ **Program of Study** (i.e., RN, PT)_____

Faculty Coordinator (if applicable)_____ **College/University**(if applicable)_____

Education Rationale: *(check one)* ☐ Career discernment ☐ Required for application to academic program
☐ Required hours for program of study ☐ VHS Employee seeking observation

#HOURS requested:_____ Date Range_____
MUST ENTER # hours *Begin & End dates*

VH Facility Preference*: WMC WMH PMH SMH HMH WAR SurgCtr Urgent Care VPE VRE Other*_____
(circle one)

Home Address: _____

City, State, Zip Code_____

Email _____ **Phone** *(circle one) Cell Home Other* _____

Learning Objectives--what you hope to learn from this experience *(state 1-3 objectives)*:

1._____

2._____

3._____

Requestor Signature: _____ **Date**:_____

Emergency Contact Name:_____ **Phone**: _____
(Print)

**Individual students may or may not be enrolled in a health professions program.*

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