

REQUEST FOR OFF-CAMPUS PLACEMENT

Please fill out the following in order to help facilitate your off-campus placement. Arrangements should be made the semester prior to your going.

NAME _____

Semester Off Campus _____

Facility Requested _____

Contact Person _____

Speech Pathologist Supervisor _____

Beginning and Ending Dates of Practicum _____

Facility Requested _____

Contact Person _____

Speech Pathologist Supervisor _____

Beginning and Ending Dates of Practicum _____

COMMENTS

Return to off-campus supervisor

Date of request _____