St. Vincent's Birmingham
Nursing School Clinical Rotation Request

Name of Nursing School: _____

Semester/Year: _____

Instructor Name: _____

Instructor Phone Office: _____

Instructor Phone Cell: _____

Instructor Email: _____

Dates of Clinical Start/End: _____

Days of week requested: _____

Shift Requested: _____

Type of Unit Requested: _____

Other Special Requests: _____

NOTE: Prior to first day of clinical experience the following required forms must be completed and turned in for each student and instructor:

1. **Schools of Nursing Student and Instructor Receipt Verification/ General Orientation Manual Non Associates & Clinical Affiliations**
2. **HIPAA Privacy and Security Agreement & Acknowledgement**
3. **St. Vincent's Health System and Affiliates Corporate Responsibility and Ethical Practices**
4. **Schools of Nursing Orientation Test**

Submit by Email Print Form