New York City College of Technology
Department of Nursing
Nursing Student Clinical Rotation

PLEASE COMPLETE ONE SHEET FOR EACH UNIT REQUESTED

Department of Nursing
Telephone: (718) 260-5660
Fax: (718) 260-5662
Contact: _____
Home Phone: _____
Course Title and Section: _____
Dates: From _____ to _____
Group/Section: _____
Pre-Conference Time: _____
Post-Conference Time: _____

Contact: _____
Semester: Fall _____ Spring _____ Summer _____
Unit Requested: _____
Days: _____
# of Students: Male _____ Female _____
Senior Instructor: _____

THIS SECTION TO BE COMPLETED BY HOSPITAL MEDICAL CENTER

DATE	DAY	TIME	UNIT	PRE-CONFERENCE ROOM	COMMENTS

APPROVED BY _____ UNIT SUPERVISION/COORDINATION _____

DATE _____ HEAD NURSE _____

REVISED FALL 2016