boomerang HEALTH | POWERED BY SickKids

OFFICE USE ONLY
Date application received _____
Applicant Placed ☐ Yes ☐ No
Preceptor _____
Start Date _____
Signature _____

Learner Request Form

First Name _____ Last Name _____

Address _____

Email _____

Telephone (Home) _____ Telephone (Cell) _____

Emergency Contact Name _____ Relationship _____

Telephone (Home) _____ Telephone (Cell) _____

Type of Request

- ☐ Student affiliated with an academic institution (i.e. completing a placement)
- ☐ Medical Resident
- ☐ Medical Fellow
- ☐ Clinical Observer (i.e. observation in patient care, up to a max. of 3 clinic days, and must be enrolled in a post-secondary institution or higher.)

Please fill out the following academic information, if applicable:

Educational Institution _____

Program of Study _____

Degree/Diploma _____

Year of Study _____ Expected Date of Completion _____

Academic Contact _____

Telephone _____ Email _____

Experience Start Date _____ Experience End Date _____

Number of Hours Required _____

Days of the week you are available for the experience

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Times (indicate the time you are available each day)							

What are your learning objectives/goals and interests?

What are your relevant experiences related to this request?

For **academic credit or clinical observership**, please email this form and your resume to **info@boomeranghealth.com,** and indicate in the subject heading "Academic" or "Observership".