

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 (observe in patient care, max. 3 clinic days, enrolled in post-secondary school or higher)
- ☐ Volunteer (must be enrolled in post-secondary school or higher)

**REQUESTS
MUST BE
SUBMITTED
AT LEAST
8 WEEKS IN
ADVANCE.**

Please fill out the following academic information, where 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 "Clinical Observership".

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IN ADVANCE.**

For **volunteer experience**, please email this form and your resume to groups@boomeranghealth.com and indicate in the subject heading "Volunteer Experience".

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