Robert Wood Johnson University Hospital | RWJBarnabas HEALTH

CLINICAL MAKE-UP TIME REQUEST FORM*

School, College, University Name: _____

Instructor Name: _____

Course Title: _____

Number of Students (not to exceed 10): _____

Make-Up Date(s) Requested: _____

Times of Requested Clinical: _____

***Please note Robert Wood Johnson University Hospital reserves the right to refuse such request and that make-up clinical time is subject to availability, unit director's and unit educator's approval.**

Authorized individual must sign statement below, or request will be returned to the school.

Make-up clinical time carries in full forces the purpose of the **CLINICAL AFFILIATION AGREEMENT** entered in to by both parties and the mutual responsibilities and expectations of RWJUH and the School and/or department of the School participating in the clinical and/or practical component of the program(s) and student, including all documentation requirements, and indemnification provisions. Nothing contained within this extension lessons or enforces any additional obligations or duties as to all parties and such accommodation is limited to this term. **IN WITNESS WHEREOF**, the parties hereto, duly authorized, have caused these present to be signed by their authorized corporate individual.

_____	_____	_____	_____ ___
Authorized signature	**Print Name**	**Title**	**Date**

FAX THIS SIGNED REQUEST TO: Nicole Rolston at 732-418-8243 at least 2 weeks prior to dates requested.