



TRAVEL STIPEND REQUEST

Date: _____

Would you consider working in a rural or medically underserved area?

Yes _____ *No* _____

Name: _____ Phone: _____	
Mail Check to _____	
City: _____ State: _____ Zip: _____	
PRACTICUM RECORD	
Dates at this Site:	<u>PRECEPTOR'S INFORMATION</u>
	Preceptor's Name:
	Name of Site:
	Site's Address:
Amount:	Student's Signature:

OFFICE USE ONLY		
Practicum record updated?	Date Updated:	Staff Initials:

NOTE: Stipend requests must be received within 60 days of completion of a clinical rotation.