

Important Information

The University of Michigan School of Nursing
Office of Multicultural Affairs

Clinical Support Project Referral Form

Date _____

Referral From _____

Phone _____

e-mail _____

Information on student being referred:

Student Name _____ Phone _____ e-mail _____

Course # _____

Course Coordinator _____ Phone _____ e-mail _____

Clinical Faculty _____ Phone _____ e-mail _____

Has the student been notified of the referral? Yes _____ No _____

Reasons for Referral

1.

2.

Outcome Objectives

1.

2.

3.

Evaluation and Grading (Please indicate how you wish this experience to be evaluated or graded)

Recommended # of hours of Clinical Support: _____

Recommendations for Clinical Support Nurse

Name

Address

Phone

e-mail

1.

2.

****Please provide a copy of the course syllabus and clinical objectives.**