DIVISION OF GRADUATE MEDICAL SCIENCES

PRACTICUM APPROVAL FORM

Please submit this form to hpeinfo@bu.edu

STUDENT INFORMATION

Name _____

Title _____

Affiliation _____

Address _____

Phone _____ Email _____

BU ID _____

YEAR IN HSE PROGRAM

☐ 1 year ☐ 2 Year ☐ 3 Year ☐ more than 3 years

INTENDED PROGRAM COMPLETION DATE

Month, Year _____

PROGRAM START DATE

Month, Year _____

PRACTICUM INFORMATION

Estimated practicum start date: _____ Estimated practicum work hours per week: _____

How did you choose your Practicum Site?

_____

PRACTICUM MENTOR

Last Name **First Name** **Degree (MD, PhD)**

Academic Affiliation and Title

Phone Email

PRACTICUM TITLE (DRAFT)

DETAILED DESCRIPTION OF PRACTICUM (include # of hours, location, and goals)

APPROVAL BY COURSE DIRECTOR (or Jeff Markuns jmarkuns@bu.edu)