Intent to Begin Clinical Training – Lactation Consultation Program

Filling out this form does not register you for Clinical Training Credit. Please complete and submit this form to the front office. If you have questions about this form or the clinical training process, contact the Lactation Program Coordinator or the Faculty Coordinator.

Student Information:

Legal First Name	Middle Initial	Legal Last Name

- **Supervising Preceptor:** An approved primary supervisor for the student as they complete clinical training.
- **Co-preceptor:** An approved preceptor in the same practice and at the same clinical site as the Supervising Preceptor, who may sometimes supervise the student in clinical training.

Intended Supervising Preceptor – clearly print their full name	Practice Name
Clinical Training Site Address:	

Co-Preceptor(s) – (if applicable) – please clearly print their full name(s)

Intended date to begin Clinical Training:____

Please initial and sign below:

____I understand that I cannot work with an unapproved preceptor and that the preceptor approval process may take a month or more from the time this form is submitted.

____ I understand that the clinical training site may have their own policies/procedures (particularly in a hospital setting) which I will need to follow.

____

Student Signature   Date

Office Use Only	Date/Time/Initial:
Please route in this order: ____ FAC ____ REG ____ LPC ____ FAC (file)	
REG	Student completion of or current enrollment in first year, first term Lactation Core Courses (per Recommended Course Sequence) verified by REG ________
FAC	Preceptor(s) approved on:
	Preceptor(s) approval pending:
	Student notified of Preceptor approval or denial on: