BIRTHINGWAY COLLEGE OF MIDWIFERY

INTENT TO BEGIN CLINICAL TRAINING

Lactation Program

Please complete and submit this form to the Faculty Coordinator. If you have questions about this form or the clinical training process, contact the Lactation Programs Coordinator or the Faculty Coordinator. It is required that all students attend the clinical training workshop, which will be offered once a year in fall term, before starting clinical training.

I, ____________________________________________, intend on starting clinical training with

(student name)

__________________________________________ on __________________________.

(preceptor name) (date)

The clinic location is:__________________________________________________________.
(Birthingway, Legacy Good Samaritan, WIC East office, etc.)

Additional preceptors at above clinic might be/are:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Please initial and sign below:

____ I understand that the preceptor approval process may take up to one month from the submission of this form. I cannot begin clinical training until the preceptor has been approved. I understand that I will be notified by the Faculty Coordinator once the preceptor has been approved, and will then be informed of the next steps I should take to begin my clinical training.

____ I understand that I might work in a particular location that has its own policies/procedures (particularly in a hospital setting) that I will need to adhere to.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Student Signature __________________________________________ Date __________

OFFICE USE ONLY:

Date/time/initial:

Please route in this order:____FAC ____LPC ____FAC ____File (faculty)

Student completion of Breastfeeding I, II, and Skills verified: __________ (initial)

Preceptor approved on __________ by ______________________________. Preceptor approval pending __________

Student notified of Preceptor approval or denial on ________________________.

Form revised on 10/18/12