## **Request for NICU Observation**

Faculty \_\_\_\_\_

Date Submitted		Course	Course Title	
Instructor Phone/E-Mai	I			
the clinical areas and may c NICU experiences are in 4 h	nd e-mailed to the on is limited in ne change requiring nour blocks only. BC rotations on	e coordinator at le umber of students student experiend Only one studen ly. We can NOT	east <b>three weeks</b> p is and time on units des to be rearrange t per clinical group allow students in p	orior to the requested dependent on the situation in ed. per day. ediatric or med/surg clinicals.
*Save this form to your desktop	o, fill in required fie	elds, save the form,	attach in e-mail and	send to appropriate CNS(s).*
Audrey Kalasky RN MSN (NICU) 248-898-5774  audrey.kalasky@corewellhealth.org  OBJECTIVES FOR OBSERVATION IN NICU/PICU				
Student Name	Date/Time Requested	Unit Requested	Unit Assigned (Completed by CNS)	Preceptor (Completed by CNS)

School \_\_\_\_\_