Clinic Registration Form

Print Name: _____ Quarter: _____

E-Mail: _____ Phone #: _____

Course #	Course Name	Hours	Units	Registering Hrs.
CL HP	Herbal Pharmacy	60 Hrs.	3	

Level I ***(Clinical Observation Internship)***

Course #	Course Name	Hours	Units	Registering Hrs.
OB 1	Clinical Observation	40 Hrs.	2	
OB 2	Clinical Observation	40 Hrs.	2	
OB 3	Clinical Observation	40 Hrs.	2	
OB 4	Clinical Observation	40 Hrs.	2	
OB 5	Clinical Observation	40 Hrs.	2	

Level II ***(Supervised Practice and Diagnosis & Evaluation)***

Course #	Course Name	Hours	Units	Registering Hrs.
CL 1	Clinical Internship	40 Hrs.	2	
CL 2	Clinical Internship	40 Hrs.	2	
CL 3	Clinical Internship	40 Hrs.	2	
CL 4	Clinical Internship	40 Hrs.	2	
CL 5	Clinical Internship	40 Hrs.	2	
CL 6	Clinical Internship	40 Hrs.	2	
CL 7	Clinical Internship	40 Hrs.	2	

Level III ***(Supervised Practice and Diagnosis & Evaluation)***

Course #	Course Name	Hours	Units	Registering Hrs.
CL 8	Clinical Internship	40 Hrs.	2	
CL 9	Clinical Internship	40 Hrs.	2	
CL 10	Clinical Internship	40 Hrs.	2	
CL 11	Clinical Internship	40 Hrs.	2	
CL 12	Clinical Internship	40 Hrs.	2	
CL 13	Clinical Internship	40 Hrs.	2	
CL 14	Clinical Internship	40 Hrs.	2	
CL 15	Clinical Internship	40 Hrs.	2	
CL 16	Clinical Internship	40 Hrs.	2	
CL 17	Clinical Internship	40 Hrs.	2	
CL 18	Clinical Internship	40 Hrs.	2	

Advanced Internship/Externship *Elective*
(Supervised Practice and Diagnosis & Evaluation)

Course #	Course Name	Hours	Units	Registering Hrs.
ACL 1	Advanced Clinical Internship	40 Hrs.	2	
ACL 2	Advanced Clinical Internship	40 Hrs.	2	
ACL 3	Advanced Clinical Internship	40 Hrs.	2	
ACL 4	Advanced Clinical Internship	40 Hrs.	2	
ACL 5	Advanced Clinical Internship	40 Hrs.	2	

Please indicate in the table below your preferred day and time to be in clinic by writing the course number under the corresponding box. For example: if you want clinic pharmacy on Friday morning then write " CL HP" in the box for Friday morning.

Rev. 022615

Morning	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00-1:00						

Afternoon	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
2:00-6:00						

If you are requesting for an internship hours at an off-site location indicate below. **Location name:** _____

Morning	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00-1:00						

Afternoon	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1:00-5:00						

Student Signature: _____ Date: _____

Clinic Director: _____ Date: _____

Registrar Signature: _____ Date: _____

rev. 040617