DISTANCE LEARNING FORM OF INTENT

STUDENT INFORMATION	
Name:	**Address:**
Email:	
Phone Number:	
SUPERVISOR INFORMATION	
Name:	**Address:**
Email:	
Phone Number:	

Expected Start Date:

Expected Completion Date:

(DL students are to register for the clinical rotation courses the semester they are expected to complete the final exam)

PLEASE ATTACH A COPY OF THE FACILITY & SUPERVISOR LETTER OF APPROVAL

Student Signature:_____ **Date:**_____

Supervisor Signature:_____ **Date:**_____