

The George Washington University
School of Public Health and Health Services



Student Practicum Plan

Instructions:

- The plan is not approved until all signatures are affixed.

Course Information:

Semester for which you are registering for the practicum (drop-down menu)

Year for which you are registering for the practicum (drop-down menu)

Practicum Information:

Agency/Organization (incl. department, division, etc.): _____

Be specific as possible

Site Address: _____

Mailing address, if different from above: _____

Site Preceptor Contact Information (if student does not have access to site profile form):

Name: _____

E-mail: _____ Phone: _____ Fax: _____

Does the practicum involve Human Subject Research? Yes ___ No ___

If yes, has it been submitted to the IRB? Yes ___ No ___

If yes, please provide IRB#: _____

Practicum Time Frame and Stipend/Pay:

Actual start date of the practicum: _____

Actual end date of the practicum: _____

Average hours per week on site: _____

How often will the Student and Site Preceptor meet for feedback?

Daily ___ Weekly ___ Bi-Weekly ___ Monthly ___

Will host organization pay/provide a stipend for the student? (Check yes/no)

If yes, amount in U.S. dollars \$ _____

Practicum Content:

Complete the following information:

<p>Title of Project</p>	
<p>List track-specific competencies that you will address in this practicum experience.</p>	
<p>List your learning objectives related to this competency.</p> <p>Description of how the experience demonstrates application of your department's practicum competencies (include a description of your major responsibilities)</p>	
<p>Activities you will conduct to build skills related to those competencies.</p>	

<p>If applicable, list and describe any reports, products or deliverables expected from the student and due dates.</p>	
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Practicum Agreement:

I have participated in the development of the Student Practicum Plan and agree to the conditions specified above. If it is necessary to change any of the specified conditions, I agree to make the changes known to each of the persons whose signatures appear below.

*Confidentiality Agreement

Student signature _____ Date _____
 Site Preceptor signature _____ Date _____
 SPHHS Practicum Director signature _____ Date _____
 SPHHS Academic Advisor signature _____ Date _____

