



MIDDLE TENNESSEE SCHOOL OF ANESTHESIA  
Request for Clinical Rotation Change Form

**Adjustment of Days for Extenuating Circumstances ONLY**

The current MTSA policy states that students will have clinical assignments no more than five (5) consecutive clinical days without a day off, and no more than an average of 50 hours per week in a four week period. There may be situations where the student may request changes that impact the consecutive days and average hours per week policy. In the event of extenuating circumstances, and if the Affiliate Clinical Coordinator has the ability to make these adjustments, MTSA will allow adjustments to be made. For instance, if a student has circumstances such that he/she needs to be off during a given period (the extenuating circumstance) and is scheduled to work during that time, the Affiliate Clinical Coordinator may be able to grant that request by allowing the student to work more days consecutively prior to, or subsequent to the event in question. In this situation, the student and the Affiliate Clinical Coordinator **must** complete this form. If another student is involved in the exchange and the exchange impacts his/her consecutive days and hours, but he/she is willing to have this exchange, this additional student must also sign this form.

By completing this form and requesting this trade, both students are fully aware that they are ASKING for this schedule adjustment, which may result in more than the 50-52 regularly scheduled weekly hours or more than the regularly scheduled five consecutive day maximum.

**Date of Request Form Completed:** \_\_\_\_\_

**Clinical Affiliate:** \_\_\_\_\_

**Date(s) of Proposed Change:** \_\_\_\_\_

**Rationale for Change:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Please Sign Below:**

**Signature of Student Requesting an Exception to the Policy:** \_\_\_\_\_

PRINTED NAME of Student Requesting the Exception: \_\_\_\_\_

**Signature of Any Other Student Involved & Willing to Exchange (if applicable):** \_\_\_\_\_

PRINTED NAME of Any Other Student Involved in the Exchange: \_\_\_\_\_

**Signature of Affiliate Clinical Coordinator Approving the Exchange:** \_\_\_\_\_

PRINTED NAME of Affiliate Clinical Coordinator: \_\_\_\_\_

Date Approved by Affiliate Clinical Coordinator: \_\_\_\_\_