CAPE FEAR COMMUNITY COLLEGE
MEDICAL SONOGRAPHY PROGRAM
Changes in clinical time

Please fax this to the college as soon as the need for a change in clinical time is determined. **362-7087 attn. Sonography**

NAME: ________________________________ **DATE**: ____________

Check one:

_____ **Make-up for time missed to fulfill requirements of attendance in clinical**

education courses.

_____ **Requested change by the clinical instructor. **Students are not permitted to request changes. (Explanation must be included below)**

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_____ **Other:** ____

Clinical Site: ____

Date(s) Requested: ____

Number of Days/Hours Requested: __________________

______________________________________ ___________

Clinical Instructor Signature Date

______________________________________ ___________

Program Director/Clinical Coordinator Date