University of North Dakota (UND) School of Medicine and Health Sciences (SMHS) Practicing Request Form

Name of emp	loyee:		
Position held	at SMHS:		
Name of facili	ty where care will be provided:		
Address of fac	cility:		
Description of	the proposed practicing services to	be provided:	
Estimated dur	ration of practicing activity: From:	To:	
Estimated hou	urly time to be spent by staff/faculty	To: hours per	
List any UND/	SMHS facilities or equipment which	will be used by the Clinician:	
•	provide documentation of waiver o	nt to UND/SMHS for use of the above facil f such reimbursement by the dean of the o	
•	he above information is correct. I ce th the performance of my assigned (ertify that the proposed practicing will be duties at UND/SMHS.	one without
		Employee signature	Date
belief that the without interf	e staff/faculty member's participation ering with the performance of the s	ed" is indicated below, it is my understand on in the proposed practicing activity can be taff/faculty member's assigned duties at U	e done
Approved	○Disapproved	Chair's signature	Date
belief that the without interf	e staff/faculty member's participation	ed" is indicated below, it is my understand in the proposed practicing activity can be taff/faculty member's assigned duties at U	e done IND/SMHS.
		Senior/Assoc Dean signatur	e Date
belief that the	e staff/faculty member's participation	ed" is indicated below, it is my understand on in the proposed practicing activity can be taff/faculty member's assigned duties at U	e done
Approved	ODisapproved	Doan's signature	
		Dean's signature	Date