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

Name of employee:
Position held at SMHS:
Name of facility where care will be provided:
Address of facility:
Description of the proposed practicing services to be provided: _____
_____

Estimated duration of practicing activity: From: _____ To: _____

Estimated hourly time to be spent by staff/faculty member: _____ hours per _____

List any UND/SMHS facilities or equipment which will be used by the Clinician: _____
_____

Describe provisions for appropriate reimbursement to UND/SMHS for use of the above facilities or equipment or provide documentation of waiver of such reimbursement by the dean of the college (see policy for examples):
_____
_____

I certify that the above information is correct. I certify that the proposed practicing will be done without interfering with the performance of my assigned duties at UND/SMHS.

_____
Employee signature Date

I have reviewed the above request and if "approved" is indicated below, it is my understanding and belief that the staff/faculty member's participation in the proposed practicing activity can be done without interfering with the performance of the staff/faculty member's assigned duties at UND/SMHS.

◯ Approved ◯ Disapproved

_____
Chair's signature Date

I have reviewed the above request and if "approved" is indicated below, it is my understanding and belief that the staff/faculty member's participation in the proposed practicing activity can be done without interfering with the performance of the staff/faculty member's assigned duties at UND/SMHS.

◯ Approved ◯ Disapproved

_____
Senior/Assoc Dean signature Date

I have reviewed the above request and if "approved" is indicated below, it is my understanding and belief that the staff/faculty member's participation in the proposed practicing activity can be done without interfering with the performance of the staff/faculty member's assigned duties at UND/SMHS.

◯ Approved ◯ Disapproved

_____
Dean's signature Date