**CLINICAL HOURS DECLARATION FORM**

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| **Programme Applicant’s Details** | |
| **Name** |  |
| **Home Address** |  |
| **Employment**  **Address** |  |
| **Phone Number** |  |
| **E-mail Address** |  |
| **Programme Title** | Please place a tick after the appropriate option:  **Minimum required MRI clinical hours**   * Advanced MR Imaging (180 hrs / 6 weeks) * Clinical & Professional Practice of MRI (190 hrs / 6 weeks) |

I verify that the above-named applicant has discussed the clinical placement requirements for their chosen MRI programme with me, and I agree to facilitate the student in achieving the specified hours.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Work Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_