University of Vermont, Master of Science in Dietetics Program
Supervised Practice Experience Rotation Summary Form

Name of Applicant: _____ _____
(First) (Last)

Instructions for completion:
If you are applying to the UVM MSD Program distance-based option you must complete this form and return it with your application materials. This form is **only required for students applying for the distance-based option**.

Part 1

1. To complete this table enter all requested facility, preceptor, and rotation details for each rotation type.
2. A single facility may be used to complete more than one type of rotation. For example, you might complete your food service management rotation and your long-term care rotation at the same long-term care facility, in which case you will enter the same facility information in both sections of the form.
3. Under the Rotation Types column you will see several rows for the same Rotation Type. For example, "Acute Care/Advanced Practice Rotation 1/2/3." This is for situations when you might complete your rotation in several different facilities and/or with several different primary preceptors. For instance, you may complete your intensive care rotation at a hospital, another rotation at a pediatric clinic, and a third rotation at a dialysis center. In this case you would complete the facility, preceptor, and rotation details for all 3 sites. Or, you might complete these same rotations within the same hospital, but in different departments with different primary preceptors, in which case you would still complete each row with the appropriate preceptor information. You may complete your Food Service Management rotation at 1 or more facilities. If the entire rotation will be completed at 1 facility with 1 primary preceptor, then you only need to complete information for Food Service Management Rotation 1.

Part 2

1. To complete this table, enter the start and end date for each rotation, the rotation type, and the facility in chronological order. That means the first line should list the first rotation you will complete at the start of rotations in January of your second semester. The second line will be the second rotation you complete, and so on.

Please feel free to reach out to MSD program staff for guidance with completing this document.

PART 1

Rotation Type	Facility Details	Primary Preceptor Details	Rotation Details	Total Hours
Clinical: General	Type:_____ Name:_____ Address:_____ City: _____ State:_____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Clinical: Oncology	Type:_____ Name:_____ Address:_____ City: _____ State:_____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Clinical: Cardiology	Type:_____ Name:_____ Address:_____ City: _____ State:_____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Clinical: Acute Care/Advanced Practice Rotation 1	Type:_____ Name:_____ Address:_____ City: _____ State:_____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	

Clinical: Acute Care/Advanced Practice Rotation 2	Type:_____ Name:_____ Address:_____ City: _____ State:_____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
			Total Hours in Clinical Rotations (should = 480+)	
Food Service Management: Rotation 1	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Food Service Management: Rotation 2	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
			Total Hours in Food Service Management Rotations (should = 224+)	
Community: Public Health Department	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	

Community: WIC	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Community: School Nutrition Program	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Community: Long-Term Care	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
Community: Student's Choice	Type:_____ Name:_____ Address:_____ City:_____ State: _____ Zip: _____ Facility Form Complete? Y ☐ N ☐	Full Name: _____ Position: _____ Credentials: _____ Years in Practice: _____ Phone: _____ Email: _____ Preceptor Form Complete? Y ☐ N ☐	Start date: _____ End date: _____	
			Total Hours in Community Rotations (should = 448+)	
			Total Cumulative Hours in ALL Required Rotations (should = 1184+ hours)	
			+ **64 Hours of Staff Relief (should = 1216+ hours)**	

PART 2

Start date	End date	Rotation type	Facility