

Supervised Experiential Learning Plan of Study Form

MPS in Nutritional Sciences, Experiential Track – DISTANCE Location Supervised Experiential Learning (SEL) Plan of Study Form					
Facility Name	SEL Site/Facility Details	Primary Preceptor Information	Duration/Dates	Affiliation Agreement	Total Hours
Clinical Supervised Experiential Learning (note: copy this blank information into a new row in this table if more than 2 sites are being used to complete clinical SEL hours)- JANUARY-MAY					
Facility #1 Name:	SEL Type: Address: City: State: Zip: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Full name: Position/Title: Credentials: Years in Practice: Phone: Email: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: End Date: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	# of hours:
Facility #2 Name:	SEL Type: Address: City: State: Zip: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Full name: Position/Title: Credentials: Years in Practice: Phone: Email: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: End Date: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	# of hours:
Community Supervised Experiential Learning (note: copy this blank information into a new row in this table if more than 2 sites are being used to complete community SEL hours) MAY-AUGUST					
Facility #1 Name:	SEL Type: Address: City: State: Zip:	Full name: Position/Title: Credentials: Years in Practice: Phone: Email:	Start Date: End Date:	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	# of hours:

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	Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Facility #2 Name:	SEL Type: Address: City: State: Zip: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Full name: Position/Title: Credentials: Years in Practice: Phone: Email: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: End Date: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	# of hours:
Food Service Management Supervised Experiential Learning (note: copy this blank information into a new row in this table if more than 2 sites are being used to complete FSM SEL hours) AUGUST-DECEMBER					
Facility #1 Name:	SEL Type: Address: City: State: Zip: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Full name: Position/Title: Credentials: Years in Practice: Phone: Email: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: End Date: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	# of hours:
Facility #2 Name:	SEL Type: Address: City: State: Zip: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Full name: Position/Title: Credentials: Years in Practice: Phone: Email: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Start Date: End Date: Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No	Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No	# of hours:

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Information Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No		
TOTAL HOURS:					