DISTANCE LEARNING SUPERVISOR AGREEMENT FORM

(To be completed by Supervisor)

STUDENT INFORMATION	
Name:	**Address:**
Email:	
Phone Number:	
SUPERVISOR INFORMATION	
Name: **Email:** **Phone Number:**	**Address:**
I certify that I am capable and willing to supervise the above-named person in the completion of the Clinical Rotation Course for the GA Institute of Technology Masters Program in Medical Physics. **?** **Board Certified** **?** **CV Attached**	
Supervisor Signature:_____**Date:**_____	