Date request received _____

REQUEST TO INITIATE NURSING AFFILIATION AGREEMENT

Remember this information will generate a legal document. All information must be accurate. Print clearly.

_____

Complete *Legal* Name of Agency

_____ _____ _____ _____

Mailing Address **City** **State** **Zip**

_____ **Starting date of program at affiliation site** ___/___/___

County

Indicate course(s) from which students will be placed _____

_____ _____ _____

Affiliate Contact Person **Title** **Phone**

_____

Affiliate Contact Person Email Address

Type of Agency (check one):

❑**Clinic** ❑**School** ❑**Community Health Agency** ❑**Hospital** ❑**Nursing Home**

❑**Other (please specify)**_____

Clinical experience for: ❑**Graduate** ❑**Undergraduate Students** (***see NOTE below***)

NOTE: *For undergraduate students*, initiation of this request will not begin unless a completed Clinical Facility Selection Form (*see College website for most current version*) is attached to this request. Call Kathy at 836-3400 if you need assistance.

I understand that when a student(s) is selected to be placed at this agency, the instructor will fulfill the responsiblities of the College of Nursing and Health Sciences as outlined in the Program Memorandum.

_____ _____ _____

Instructor's Signature **Email Name** **Date**

_____ _____

Department Chair Signature **Date**

Upon completion forward to K. Tank, NURS 247.

For Official Use Only
Date Mailed _____ Date Returned _____
Spreadsheet Entry ❑