Attachment 1

TEXAS STATE UNIVERSITY
COLLEGE OF HEALTH PROFESSIONS
REQUEST FOR AFFILIATION AGREEMENT

DATE:

It is requested that approval be given for obtaining an affiliation agreement with <<Facility Name>> for the purpose of placing a student in an internship/residency/clinical practice.

It is desired that students be placed in this agency under the agreement beginning <<Date>>.

Contact Person: _____
Name

_____
Title

_____
Street

_____
City/State/Zip

_____
Email

Send Via: Email or Mail
Circle One

Justification:

Clinical Education Coordinator: Approved: _____ Date _____

Disapproved: _____ Date _____

Dept/Program Chair: Approved: _____ Date _____

Disapproved: _____ Date _____