Clinical Site Affiliation Request Form

St. David’s School of Nursing, Texas State University

**Note:** The contact for the affiliation agreement must be authorized to enter into contracts on behalf of the facility (or handle them for the administrator who does).

**Facility Information**

Name: ________________________________

Address: ________________________________

City/State/Zip: ________________________________

Average Age Range of Patients: ________________________________

Specialty Focus (i.e. pediatrics, women’s health, etc.): ________________________________

*Please check the appropriate box indicating the classification of this facility (*most commonly used)*

- [ ] Private Practice
- [ ] Community Health Center (CHC)
- [ ] Health Care for Homeless
- [ ] Health Profession Shortage Area (HPSA)
- [ ] Behavioral Health
- [ ] Federally Qualified Health Center (FQHC)
- [ ] Rural Health Clinic
- [ ] Other: ________________________________

**Contact Information**

Name: ________________________________

Title: ________________________________

Phone: ________________________________

Email: ________________________________

Fax: ________________________________

Does the contact prefer to receive the Agreement via email or regular mail?

- [ ] Email
- [ ] Mail

Please return to the student.
(Students, please submit to:)

nurs_clnclplcmnt@txstate.edu

Office Use Only

Reviewed By: ________________________________

Program: [ ] FNP [ ] PMHNP [ ] LAN

Program Director ________________________________ Date ________________________________

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