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) ☐ Behavioral Health
☐ Health Care for Homeless ☐ Federally Qualified Health Center (FQHC)
☐ Health Profession Shortage Area (HPSA) ☐ 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 your Typhon account)

Program: ☐ FNP ☐ PMHNP ☐ LNP

Office Use Only
Approved By: ____________________________ Date

Faculty Signature ____________________________

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