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 ☐ Behavioral Health
☐ Community Health Center (CHC) ☐ Federally Qualified Health Center (FQHC)
☐ Health Care for Homeless ☐ Rural Health Clinic
☐ Health Profession Shortage Area (HPSA) ☐ 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.

Student please submit to the Clinical Placement Coordinator

Program (all that apply): ☐ FNP ☐ PMHNP ☐ LAN

Office Use Only
Approved By: ______________________(Director) Signature________________________

Date ________________

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