TEXAS STATE UNIVERSITY

The rising STAR *of Texas*

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.
Student please submit to the Clinical Placement Coordinator

Office Use Only
Approved By:

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

_____(Director) Signature_____

Date _____

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