Clinical Site Approval 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)
- [ ] Urgent Care
- [ ] 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
Approved by [ ] Program Director, Program: [ ] FNP [ ] PMHNP

________________________________________________________________________
Signature Date

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