MEDICAL UNIVERSITY OF SOUTH CAROLINA COLLEGE OF NURSING
AFFILIATION AGREEMENT REQUEST FORM

PLEASE READ CAREFULLY BEFORE FILLING OUT THIS FORM

To request an Affiliation Agreement, please complete this form, and have your faculty sign before submitting to the Clinical Placement Department at the College of Nursing.

Clinical Affiliation Agreement Deadlines
Please Note: The following timelines should be observed for new clinical sites:
1-2 months prior to the beginning of the clinical for individual students.
2-3 months prior to the beginning of the clinical for a student in a hospital, government or large agency.

Please Remember: This form is NOT an agreement! This is ONLY the request form needed to begin with the proceedings of an actual legal agreement or contract. Each site involved must be in possession of a copy of a fully executed agreement or contract, BEFORE the student may begin with clinicals.

FACILITY INFORMATION:

Complete Legal Name of Facility _____ **Street Address of Facility** _____

Facility City, State and Zip Code _____ **Facility's Phone Number** _____ **Facility's Fax Number** _____

Facility's Contact Person (Full Name) _____ **Title** _____ **Phone (incl. Area Code)** _____ **Facility Contact Email Address** _____

Name of Authorized Rep or Signee of Agreement _____ **Authorized Rep's Title** _____

Will site permit multiple assignments? ☐ YES ☐ NO ☐ UNKNOWN
Does site provide housing? ☐ YES ☐ NO ☐ UNKNOWN
Is facility in a Health Professional Shortage Area? (HPSA) ☐ YES ☐ NO ☐ UNKNOWN
Is facility a Medically Underserved Area (MUA). . . . . ☐ YES ☐ NO ☐ UNKNOWN
Is facility a Rural Health Clinic? (RHC) ☐ YES ☐ NO ☐ UNKNOWN
Is facility a Community Health Center? (CHC) ☐ YES ☐ NO ☐ UNKNOWN
Is facility a Federally Qualified Health Center? (FQHC)?. . . ☐ YES ☐ NO ☐ UNKNOWN
In which county is this facility located? _____
Is facility owned by a Parent Company?* ☐ YES ☐ NO ☐ UNKNOWN

*** If YES,** provide the following information on the Parent Company:

PARENT COMPANY INFORMATION:

When a facility is owned by a parent company, the Affiliation Agreement must indicate the name of the parent company rather than the individual facility. Therefore, this information is critical in order to complete your request.

Full Legal Name of Parent Company _____ **Street Address of Parent Company** _____

City, State and Zip Code _____

Contact Person at Parent Company _____ **Title/Email Address** _____ **Phone (incl. Area Code)**

Student's Name and Signature: _____

Is student presently employed at this facility? ☐ **YES** ☐ **NO**

Student's Email: _____

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Clinical Site Approval Form

Information Required for Clinical Site Contract

SITE DEMOGRAPHIC INFORMATION

Clinical Site Name:_____

Address: _____

City: _____ State _____ Postal Code _____

Website _____

Current Clinical Contract with MUSC CON on file? ☐ Yes; ☐ No; ☐ Unknown

SITE CHARACTERISTICS (Check All that Apply):

☐ Community/Home Care (hospice, assisted living)
☐ Psychiatric
☐ Government Agency (law enforcement, military)
☐ Public Health
☐ Specialty Care (neurology, cardiology, etc.)
☐ Long Term Care
☐ Primary Care (family practice, pediatrics, etc.)
☐ Tertiary Care (hospital)
☐ Private Practice
☐ Other: _____

EXPERIENCES AVAILABLE (Check All that Apply):

☐ Acute ☐ In-hospital ☐ Primary Care

☐ Chronic ☐ Outpatient ☐ Other: _____

PATIENT CHARACTERISTICS (Check All that Apply):

Gender: ☐ Female: ☐ Male

Age Group(s):
☐ Newborn/Infants (birth to 1 year)
☐ Pediatrics (> 1 year to < 18 years)
☐ Adults (18 years to 65 years)
☐ Older Adults (> 65 years)

Ethnicity/Race:
☐ American Indian/Eskimo Aleut
☐ Asian/Pacific Islander
☐ Black
☐ Latino
☐ White

Evaluation of site and experience:

1. How many patients will you be able to see on a daily basis with the preceptor: _____
2. How many exam rooms at this facility: _____
3. Will the student be able to access labs and x-ray reports: ☐ Yes ☐ No
4. Will the student be able to document in the chart or electronically: ☐ Yes ☐ No
5. On average how much time is spent with each patient: _____
6. Is there adequate space at this site for a student: ☐ Yes ☐ No
7. What type of procedures will the student be exposed to with this preceptor and allowed to perform. List all that apply:

Clinical Preceptor Information Form/Abbreviated CV

Information required on all Preceptors

Date:_____ Student Name:_____

Preceptor: Last Name: _____ First Name: _____

Title: _____ Credentials: _____

Practice/Clinical Site: _____

Work Address: _____

City: _____ State: _____ Postal Code: _____

Work Phone: _____ Cell Phone: _____

E-mail address: _____

Citizenship/Visa Status: _____

PRECEPTOR DEGREE INFORMATION (Check All that Apply)

Type of Degrees:

☐ DNP	☐ DNSc/DNP	☐ DO	☐ DrPH	☐ PA
☐ EdD	☐ JD	☐ MS/MSN	☐ MA	☐ MBA
☐ MD	☐ ND	☐ PharmD	☐ PhD	☐ Other:

EDUCATION (Baccalaureate and Above)

Institution	Years Attended	Degree Date	Field of Study
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRECEPTOR LICENSE INFORMATION *(Attach Copies):*

Type of License: _____ State License Issued: _____
License #: _____ Expiration Date: _____

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PRECEPTOR CERTIFICATION INFORMATION: *(Attach copies)*

Current Certification #1: _____ **Certifying Body:** _____

Expiration Date: _____ Years in Specialty Area: _____

Current Certification #2: _____ **Certifying Body:** _____

Expiration Date: _____ Years in Specialty Area: _____

Preceptor Information (cont.)

EMPLOYMENT: (Chronological for past 10 years)

Institution	Position	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRECEPTOR PRACTICE INFORMATION (Check All that Apply)
Preceptor's Practice Specialty:

☐ Acute Care	☐ Administration	☐ Allergy/Immunology	☐ Anesthesia
☐ Cardiology	☐ Critical Care	☐ Dermatology	☐ Emergency
☐ Family Practice	☐ Forensics	☐ Gerontology	
☐ Internal Medicine	☐ Neonatal	☐ OB/GYN	☐ Oncology
☐ Ophthalmology	☐ Orthopedics	☐ Otolaryngology	☐ Pediatrics
☐ Psychiatric	☐ Public Health	☐ Surgery	☐ Trauma

☐ Other: _____

I have attached my abbreviated CV, Licensure and certification

_____ _____
Preceptor Signature Date

_____ _____
Signature of Student Student Date