

MEDICAL UNIVERSITY OF SOUTH CAROLINA COLLEGE OF NURSING

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):

- | | |
|---|---|
| <input type="checkbox"/> Community/Home Care (hospice, assisted living) | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Government Agency (law enforcement, military) | <input type="checkbox"/> Public Health |
| <input type="checkbox"/> Specialty Care (neurology, cardiology, etc.) | <input type="checkbox"/> Long Term Care |
| <input type="checkbox"/> Primary Care (family practice, pediatrics, etc.) | <input type="checkbox"/> Tertiary Care (hospital) |
| <input type="checkbox"/> Private Practice | <input type="checkbox"/> Other: _____ |

EXPERIENCES AVAILABLE (Check All that Apply):

- Acute In-hospital Primary Care
- Chronic Outpatient Other: _____

PATIENT CHARACTERISTICS (Check All that Apply):

Gender: Female: Male

Ethnicity/Race:

Age Group(s):

- | | |
|--|---|
| <input type="checkbox"/> Newborn/Infants (birth to 1 year) | <input type="checkbox"/> American Indian/Eskimo Aleut |
| <input type="checkbox"/> Pediatrics (> 1 year to < 18 years) | <input type="checkbox"/> Asian/Pacific Islander |
| <input type="checkbox"/> Adults (18 years to 65 years) | <input type="checkbox"/> Black |
| <input type="checkbox"/> Older Adults (> 65 years) | <input type="checkbox"/> Latino |
| | <input type="checkbox"/> 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:

**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 <u>Legal</u> 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: _____

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:

- | | | | |
|--|---|---|-------------------------------------|
| <input type="checkbox"/> Acute Care | <input type="checkbox"/> Administration | <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Anesthesia |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Critical Care | <input type="checkbox"/> Dermatology | <input type="checkbox"/> Emergency |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Forensics | <input type="checkbox"/> Gerontology | |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Neonatal | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Public Health | <input type="checkbox"/> Surgery | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Other: _____ | | | |

I have attached my abbreviated CV, Licensure and certification

Preceptor Signature

Date

Signature of Student Student

Date