CLINICAL AFFILIATE APPLICATION

• This application must be completed by programs applying for recognition of a clinical affiliate(s).
• Use a separate application form for each clinical affiliate.
• Return this application, supporting documentation, and $100 application fee to: AC-PE; 6654 S. Sycamore St, Littleton, CO 80120.

A. Sponsoring Institution: ____________________________________________________________

B. Clinical Affiliate: ________________________________________________________________

   Address: _____________________________________________________________

   City, State & Zip: __________________________________________________________

   Is the affiliate accredited? ______Yes ______No

   Accreditation agency: ________________________________________________________

   Term of current award: _______________________________________________________

   When did the program director/clinical coordinator visit the affiliate? ______________

   When will students begin clinical rotations at the site? ____________________________

C. Student Capacity

   Length of clinical rotation at this site: ____________________________________________

   Number of students from this sponsor’s perfusion class: ____________________________

   Number of students from other sponsoring organization: __________________________

   Number of full-time certified perfusionists: ________________________________

   Total number of procedures annually: ___________________________________________
Number of cases by type:  

- CABG on-pump  
- Autotransfusion  
- Valves  
- Pediatric  
- Infant  
- VADS  
- ECMO  
- IABP  
- Limb  
- Hemoconcentrator  

Transplants:  

- Heart  
- Lung  
- Liver  

List ancillary techniques:  

___________________________________________________________________________  

___________________________________________________________________________  

___________________________________________________________________________  

D. Clinical Affiliate Officials  

Chief Executive Officer of the Clinical Affiliate or Other Designated Senior Official  

Name and Title:  

Address:  

City, State & Zip:  Phone:  

Signature  

Perfusion Manager of the Clinical Affiliate  

Name and Title:  

Address:  

City, State & Zip:  Phone:  

Signature  

Director of Perioperative Services or equivalent Administrator or Manager  

Name and Title:  

Address:  

City, State & Zip:  Phone:  

Signature  

Revised: June 2005 2
The clinical site’s designated staff has read and agrees to abide by *the Standards and Guidelines for an Accredited Educational Program for the Perfusionist (Standards)*. The designated clinical staff agrees to provide clinical education in compliance with the *Standards*. It is further understood that in order to supervise students operating extracorporeal circulation equipment, the clinical instructor must be certified.

Clinical Instructor(s):

1. Name:_________________________________________________________
   Signature:_____________________________________________________

2. Name:_________________________________________________________
   Signature:_____________________________________________________

3. Name:_________________________________________________________
   Signature:_____________________________________________________

4. Name:_________________________________________________________
   Signature:_____________________________________________________

5. Name:_________________________________________________________
   Signature:_____________________________________________________

E. Attachments

☐ 1. Provide narrative that documents rationale for the establishment of the clinical affiliate.

☐ 2. Provide an inventory of equipment and supplies available at the clinical site.
   (Include Heart, Autotransfusion, IABP, and other support.)

☐ 3. Provide verification of malpractice insurance coverage, if required by the affiliation agreement.

☐ 4. Signed affiliation agreement.

☐ 5. Documentation of clinical affiliate accreditation (certificate or letter).

☐ 6. *Curriculum Vitae Form* for each listed clinical instructor.

☐ 7. $100 application fee.
CURRICULUM VITAE FORM
CLINICAL INSTRUCTOR

- Please copy this page for each clinical instructor.

<table>
<thead>
<tr>
<th>Name (last, first, middle initial)</th>
<th>Title</th>
</tr>
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<tbody>
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</table>

**Education**
(Begin with baccalaureate or other initial professional education and include postdoctoral training. Identify all post-high school education in chronological order.)

<table>
<thead>
<tr>
<th>Instruction</th>
<th>Degree</th>
<th>Year Conferred</th>
<th>Area of Study</th>
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Professional credentials, including specialty designation(s). (Include xerox copy of credential.)

Continuing professional development, last two years.

List previous employment experience in reverse chronological order.