

Appendix B Affiliation Agreement Request Form

PLEASE READ CAREFULLY BEFORE FILLING OUT THIS FORM

To request an Affiliation Agreement with a facility, please complete this form, have your faculty Advisor sign before forwarding to the attention of Anette Hebebrand-Verner, Academic Office, CON Room 221C, at least 2 months prior to student placement.

Facility Information:

Complete Legal Name of Facility	Street Address of Facility
City, State and Zip Code	
Main Telephone Number Fax Number	Email of Contact Person at Facility
Facility Contact Person (Full Name) Title	() Phone (incl. Area Code)

The information requested below is needed for the University Clinical Sites Database.

Will site accept 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 in a Medically Underserved Area (MUA)?.....	Yes	No	Unknown
Is facility a Rural Health Clinic?.....	Yes	No	Unknown
Is facility a Community Health Clinic?.....	Yes	No	Unknown
Is facility a Federally Qualified Health Center (FQHC)?.....	Yes	No	Unknown
In which country 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.

Complete 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)

Faculty Member Submitting Request: _____

Student's Name: _____

Online Students: Is student presently employed at this facility? Yes No Unknown

Student's Email: _____