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

________________________________________________________

City, State and Zip Code

Facility’s Phone Number

Fax Number

Email of Contact Person at Facility

Facility Contact Person (Full Name)

Title

Phone (incl. Area Code)

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 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: __________________________________________