

Course # _____

Date : _____

CLINICAL PLACEMENT INFORMATION
New Renewal Expiration Date _____

Student Requesting Clinical Placement: _____

Name of Agency: _____

Address: _____
Street City State Zip Code County

Telephone: _____ Fax # _____

E-mail Address _____ Accredited by: _____ (if applicable)

Name of person responsible for signing contracts: _____

Title: _____ Telephone: _____

A) If your agency is covered by a current contract with another agency, please provide us with the name, address and telephone number of the parent organization. _____

B) If your agency owns or operates other agencies, that would be covered by this contract, please provide the name, address and phone number of these organizations, as well (Please use additional paper if this does not provide enough space). _____

NOTE: If the above placement is used for an individual Master's or RN BSN Students for solo practices and partnerships, this person will most likely be the preceptor. Within some partnerships, this responsibility may rotate among them internally. For health care corporations, this will usually be a director or vice-president.

Title of liaison/preceptor for clinical placements: _____

Preceptor's Name: _____ Telephone: _____

In a solo practice or partnership, this individual is the office manager or the business manager. This person is the one who is responsible for correctly routing the paperwork within the practice. Be aware that a contract CANNOT be kept secret from other partners in a partnership. When the document is signed by the physician(s), it obligates the PRACTICE, not just the individual preceptor (unless substantial changes are made to the document--which then significantly slows the process). In health care corporations this is usually a member of the nursing department.

1. Check one: a corporation (hospital, organization, company); a partnership (more than one affiliate in a practice); a solo practice (one affiliate in a practice); other (specify legal entity status: _____)

2. If an acute agency: Bed Capacity _____ Average Daily Census _____

If the agency has a bed capacity and an average daily census, fill in the blanks. If not, put NA. This information is important for College records. It provides statistical information required by the government.

OVER

Please check the box below by the appropriate information for the agency you are requesting. More than one block can be checked. (Check all that apply).

POPULATION SERVED

- HPSA- Health Professional Shortage Area
- MED UND – Medically Underserved
- RURAL
- URBAN

FACILITY TYPE

- Community Health Center (01)
- Dental HPSA (02)
- Health Care for the Homeless Grantee (03)
- Public Housing Primary Care Grantee (04)
- Rural Health Clinic (05)
- Federally Qualified Health Center (06)
- Ambulatory Practice Site Designated by State Governors (07)
- Primary Medical Care Health Professional Shortage Area (HPSA) (08)
- Practice and/or facility – 50% patients are Medicaid recipients (or eligible) and uninsured (09)
- Migrant Health Center (10)
- National Health Service Corps Site (11)
- Nurse Shortage Area (12)
- State or Local Health Department (13)
- Indian Health Service Site (14)
- Other

PRACTICES

- Acute Care (01)
- Adult (02)
- Adolescent (03)
- Case Management (04)
- Chronic/Long Term (05)
- Community Health (excludes Public Health)(06)
- Critical Care (07)
- Environmental (08)
- Family (09)
- Geriatric/Gerontology (10)
- Genetics (11)
- Home Health (12)
- Immunosuppressive Nursing (13)
- Maternal-Child/Parent-Child Health (14)
- Medical-Surgical (15)
- Neonatal (16)
- OB/GYN/Women's Health (17)
- Occupational Health (18)
- Oncology (19)
- Pediatrics (20)
- Perinatal (21)
- Primary Care (22)
- Psychiatric-Mental Health (23)
- Rehabilitation (24)
- School Health (25)
- Other : _____(99)