

## Student Affiliation Agreement Form

Please complete this form to request that a Student Educational Affiliation Agreement be initiated with the facility listed below. Please e-mail the completed form to Shawna Cleary at [clearys4@southernct.edu](mailto:clearys4@southernct.edu) or Cynthia Shea-Luzik at [shealuzik1@southernct.edu](mailto:shealuzik1@southernct.edu).

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1. Are you requesting a precepted student experience?        YES        NO

2. Date agreement is to begin: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. Number of Program Evaluations between the Facility (SCSU) & the Institution. \_\_\_\_\_

4. Facility Information:

Name of Hospital or Clinical Site:	
Street Address:	
City, State, Zip:	
Contact Name:	
Contact Email:	
Contact Telephone:	

5. Requesting SCSU Department Information:

Your Name:	
Your Department:	
Your Email:	
Your Telephone:	

***THIS SECTION FOR CONTRACT COMPLIANCE USE ONLY***

***Received by:*** \_\_\_\_\_                      ***Date received:*** \_\_\_\_\_

***Agreement sent to Facility on:*** \_\_\_\_\_                      ***Signed agreement received:*** \_\_\_\_\_