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 or Nina Cote at coten1@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:*** _____