Request for Affiliation Agreement

Please make sure all information is filled out **in its entirety.** Any missing information will cause a delay in processing the affiliation agreement. Once completed, click the submit form button. Thank you.

Your Name: _____

Your concentration: ☐ FNP ☐ PNP ☐ ACNP

Student Contact phone number: _____

Student Contact email: _____

Name of Preceptor: _____

Preceptor's Professional Designation:

☐ MD ☐ DO ☐ CNM ☐ FNP ☐ WHNP ☐ PNP ☐ ANP ☐ PA ☐ ACNP

Have you spoken to the preceptor? ☐ YES ☐ NO

Has she/he agreed to serve as your preceptor? ☐ YES ☐ NO

Has she/been a preceptor for UTEP before? ☐ YES ☐ NO

Do you have a personal relationship with the Preceptor or work with them?

If yes, please explain: _____

_____

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Office of Research and Sponsored Projects

Name of Facility: _____

Is facility (check): **Profit** ☐ **or** **Non Profit** ☐

Address: _____

_____

_____

Facility's contact person: _____

Title: _____

Telephone: _____

The above person has been contacted regarding proposed request: ☐ **Yes** ☐ **No**

Baccalaureate Program: _____ **Master Program:** X_____ **Ph.D Program:** _____

Program Area: Masters of Science in Nursing

Students participating in program shall have completed 2____**years at the approved degree program.**

Students will be allowed in the Facility during the regular academic period. Semester start dates are:

January 16 - Spring ☐ **Year** _____ **June 01 - Summer** ☐ **Year** _____ **September 16 - Fall** ☐ **Year** _____

Start date and Year plus 5 YEARS _____

Affiliation Agreement requested by: Dr. Leslie H. Robbins

(UTEP Requestors Name)

Name/Title: Interim Assistant Dean Graduate Nursing **Extension No.** 7227

Department/College: The University of Texas at El Paso School of Nursing

Recommended Approval:

Department Chairperson: _____ **Date:** _____

Academic Dean: _____ **Date:** _____