ALLEGANY COLLEGE of MARYLAND
NURSING

Clinical Facility Agreement Request Form-LPN to RN Online Program

Please NOTE: This form is NOT an agreement!! This is **ONLY** the request form needed to begin 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 clinical experiences. **This is to be completed by the student, not the requested facility.**

Date: _____Course Number: _____Course Title: _____

Semester (Circle): Fall ____Spring _____Year: _____ Preference (Circle): 1 ___ 2 ___ 3 ___

***** Please Print Legibly. Incomplete or Illegible forms will *significantly* delay process. *****

Student: First Name:_____Last Name: _____

Phone:_____Student ID #_____ACM Email: _____
Circle one: Home Cell Work

Student Availability: (check all that apply): _____M___T___W___T___F___S___S__ Shift: Day___Eve___Night___

Please note that this is a preference and may not be able to be met. Night shift must have prior approval before beginning hours.

Clinical Agency Information:

Legal Name of Facility- NOT Initials_____

Street_____City_____ State_____ Zip_____

Phone Number (incl. area code)_____ Fax Number_____

Facility Contact Person_____Title _____

Business email address of Contact Person_____ Phone Number _____

Name and Title of person at agency **authorized** to sign Clinical Contract Agreement _____

** *When a facility is owned by a parent company, the Agency Agreement Contract must indicate the name of the parent company rather than the individual facility. Therefore, this information is critical in order to complete your request.*

Is facility owned by a **Parent Company?** YES NO UNKNOWN **If YES**, provide following information on **Parent Company**:

_____ _____
Full Legal Name of Parent Company Street Address of Parent Company

_____ _____
City State Zip Code Phone w/area code

Name of Contact Person at Parent Company_____Title _____

Is student presently employed at this facility? YES NO *** If Yes**, Name of Immediate Supervisor: _____

I understand that I am responsible for identifying a clinical agency site and a clinical preceptor to meet the course requirements of clinical nursing courses and failure to do so will result in forfeiture of my seat in the program. I understand I must submit the following forms to the LPN-RN datacenter eight weeks prior to the start of each clinical semester: ~ Clinical Agency Agreement Request Form ~ Clinical Preceptor Request Form
*Preceptor Letter of Agreement **&** *Clinical Preceptor Professional Profile/ CV (preceptor submits- student ascertain item submitted)
I further understand that I may not begin my clinical hours until all forms have been submitted to the Department of Nursing; an active affiliation agreement with the clinical site is in place; the preceptor and nurse manager forms are on file and approved; my preceptor has been approved; and I have been given final approval to begin my clinical hours.

Student Signature:_____**Date:** _____

This form must be e-mailed to rnclinicals@allegany.edu or faxed to 301-784-5106 Attn: LPN to RN Online Program.

For College Use Only: Contract in Place: **Yes**_____ **Effective Dates:** _____
if **No**_____Date Sent to Agency_____ Contract (circle) Approved / Denied Date: _____
Faculty Signature:_____ **Approve/Filed Date**: _____
Faculty Signature:_____ **Review Date:**_____

Re: 2/2022; 10/2019; 5/2012; June 2011.