COLLEGE OF NURSING & HEALTH SCIENCES
COMMUNICATION SCIENCES & DISORDERS
REQUEST FOR AFFILIATION AGREEMENT

DATE: _____

NAMEOF
AGENCY: _____

ADDRESS OF
AGENCY: _____

(ZIP)

NAME & TITLE OF
ADMINISTRATOR: _____

PHONE: (___) _____ EXT: _____

FAX: (___) _____

E-MAIL: _____

DATE FACILITY WAS ESTABLISHED: _____

OTHER PROGRAMS TO BE INCLUDED IN THE AGREEMENT. Please Check:

❑Physical Therapy	❑Athletic Training	❑Social Work
❑Public Health	❑Psychology	❑Nursing
❑Dietetic & Nutrition	❑Recreation Therapy	❑Occupational Therapy

Contact information for ASHA CERTIFIED CLINICAL SUPERVISOR

NAME: _____

TITLE: _____

PHONE: (___) _____ EXT: _____

EMAIL: _____

CCC #_____

DATE ON WHICH YOU WISH AFFILIATION TO BEGIN:

_____

ADDITIONAL COMMENTS:

_____

_____

FIU COORDINATOR OF CLINICAL EDUCATION:

_____

INITIAL CONTRACT ❑ RENEWAL CONTRACT ❑