CLINICAL AFFILIATION CONTRACT INITIATION

Facility Name: _____

Mailing Address: _____

_____

_____

Phone: _____ Fax: _____

Website: _____

Physical Address (if different): _____

_____

_____

CCCE Name/Credentials/Clin Exp: _____

Phone: _____ E-mail: _____

1. Please check ONE box that best describes your facility: O Acute Care Hospital O Ortho/Sports Rehab

O Pediatric O Inpatient Rehab O Subacute/SNU/SNF/TCU O CORF

O Long-term Acute Care O Outpatient Rehab

2. Number of PT's at facility: ____

3. Other clinical staff (certification, number of staff): _____

4. Do you have current contracts with other student programs? O Yes O No

_____

5. Will you use ASU's contract or do you have a Facility Contract? O ASU O Facility

6. Legal contact or contract manager: _____

Phone: _____ E-mail: _____

Mailing Address: _____

_____

_____

Other comments: _____

_____

Reviewed by ACCE: _____