

**ANGELO STATE UNIVERSITY
INSTITUTIONAL RESEARCH AND ASSESSMENT**

PHONE NUMBER: _____ E-MAIL ADDRESS: _____

REQUESTED BY: _____

DATE OF REQUEST: _____ DEPARTMENT: _____

REQUEST FOR NURSING CLINICAL EVALUATION FORMS

INSTRUCTOR:

NAME: _____ NUMBER: _____

COURSE

TITLE: _____ NUMBER: _____

EVALUATION FORM NEEDED:

Student Evaluation of Clinical Facility

NUMBER OF FORMS NEEDED: _____ DATE TO BE ADMINISTERED: _____

SPECIAL INSTRUCTIONS: _____

Student appraisal of Teacher Effectiveness-Clinical

NUMBER OF FORMS NEEDED: _____ DATE TO BE ADMINISTERED: _____

SPECIAL INSTRUCTIONS: _____

APPROVED BY: _____ DATE: _____

(Head of Department)

1. IF EVALUATION FORMS ARE BEING REQUESTED FOR MULTIPLE COURSES WITHIN A DEPARTMENT, THE TOP PORTION OF THIS FORM SHOULD BE COMPLETED, AND A LIST PROVIDING ALL THE INFORMATION REQUESTED ABOVE MAY BE ATTACHED.
2. THIS FORM MUST HAVE APPROPRIATE SIGNATURE OF APPROVAL.
3. REQUESTS FOR EVALUATION FORMS SHOULD BE SUBMITTED 6 WEEKS BEFORE THE DATE THEY ARE NEEDED.

FOR IR&E USE ONLY:

DATE RECEIVED: _____

DATE PRINTED AND SENT TO DEPT: _____