Date Request to Board: \_\_\_\_\_



PENNSYLVANIA STATE BOARD OF NURSING P.O. BOX 2649 HARRISBURG, PA 17105-2649

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## AGENCY DATA FORM

The Board must have the following information to determine the adequacy of the clinical facilities for the nursing education program before approval can be granted and the site used. A site visit may be made if indicated.

Program Type:	Associate Baccala		eate Diplo	ma Practical						
Name of Nursing Education Program										
Address(Street)	(City)	(State) (	Telephone Zip Code)							
Name of Agency to be Used										
Address(Street)	(City)	(State) (Zi	p Code)							
Name of State/Federal Licensi	ng Agency									
(If applicable) Approval Status:	FullProvisional	I Last Visit	Approval Period	to						
Name of Accrediting Agency										
(if applicable) Approval Status:	FullProvisional	Last Visit	Accreditation Period	dto						
Agency Administrator										
Director of Nursing										
Agency Contact Person Telephone										
Number of Potential Clients:										
b. Classro c. Office S d. Number	able? /Resource Information poms/Conference Room Space/Equipment	[ ] [ ns [ ] [ [ ] [ rience/student:	] 2. Letter	I Objectives of Intent/rationale for use						
Education Program Director's Sig	gnature and Date:									
Printed name and title of clinica use of clinical areas indicated o		pproving								
Signature of clinical agency repr	resentative and Date:									

## <u>PLEASE NOTE</u>: For Required State Board of Nursing Approval <u>ALL</u> COLUMNS FOR EVERY PROGRAM <u>MUST BE COMPLETED in Detail</u>

Name of <b>ALL</b> nursing education programs using facility (include all programs including all out-of-state programs)	Specific clinical area or Unit used by students	Average daily Patient census on unit(s)/ average # of weekly visits	Average number of Students assigned at one time	Faculty- student Ratio	Specify Schedule		
					Dates of Rotation	Time(s) of Day	Specific Days

Dvlpd: 3/03; Rev: 10/06