PARKVIEW HEALTH

Parkview Health
Request for Educational Affiliation

Parkview Health – Educational Affiliation Agreement

Page 1 refers to student and institution information.

Student Name: ____

Expected Graduation Date: ________________________

Educational Institution: ____

Institution Address: ____

Institutional Contact: ____

Telephone number: _______________________ Email:________________________________

Institutional Accreditation: ____

Educational Program for which affiliation is being requested and academic credential that is awarded upon completion of program:

____

Administrative person responsible for educational program: _____________________________

Telephone number: _______________________ Email________________________________

Programmatic Accreditation: ____

PARKVIEW HEALTH

Page 2 refers to desired Parkview Health internship details.

Clinical/Operational area of Parkview Health where the educational experience is being requested:

____

Parkview Health contact that has agreed to the request:
____

Parkview Health contact phone number:
____

Parkview Health contact email:
____

Describe the educational experience that is being requested: ____________________________

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Planned Experience start date: _________________________

Please attach a copy of student course goals and objectives when returning document.