Facility

Institution Name:

Address:

City, State, Zip:

Telephone:

Facility Accreditation Information

Accredited by (check all that apply):

TJC [ ]  CLIA [ ]  COLA [ ]  CAP [ ]

# Other:

Clinical Liaison as required by Standard VII.C.2

Name:

Position:

Education:

Length of experience as a health care professional:

Types of positions held in the field:

For each of the following clinical areas, please identify:

|  |  |  |
| --- | --- | --- |
| **Department** | **# of students in clinical/applied learning at one time** | **Length of clinical/applied learning** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

For additional lines, go to Review, click Restrict Editing, then Stop Protection. Add the lines you need, then once finished, go back and click Yes, Start Enforcing Protection.