Janice. K. Brewer
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing
4747 North 7th Street, Suite 200
Phoenix. AZ 85014
Phone (602) 771-7800 Fax (602) 771-7888
E-Mail: arizona@azbn.gov Home Page: http://www.azbn.gov

HEALTH CARE FACILITY AVAILABILITY FORM

Programs seeking provisional approval or to expand capacity need to complete one form for each clinical health care facility where new or additional students will be placed for 2 years. The information contained in this form will provide evidence for the Board to determine if the program meets the requirements of R4-19-207(D)(2)(f) for provisional approval applicants and R4-19-209 (B)(1) for existing program applicants.

Name of School: Program: RN LPN Multiple-Exit	Name of Director/Designee: Telephone number: E-mail Address:
Name of Health Care Facility: Type of health care facility (Acute, OPD, SNF, Public Health etc.) Average Daily Census for the agency:	Name of Facility Contact/Student Placement Coordinator: Telephone Number: Email Address:

Type of units where students can be placed	**Medical-Surgical**	**L&D/ Couplet Care**	**Pediatrics**	**Psych-Mental Health**	**Geriatrics**	**Critical Care/ Special Care**	**Community Health/ Home Health**
Number of **GROUPS** the program is planning to place in the clinical area per academic YEAR (indicate year).	200_	200_	200_	200_	200_	200_	200_
	200_	200_	200_	200_	200_	200_	200_
Shifts (circle one) and days of the week available for placement of student GROUPS (Attach extra sheets as needed) D=DAYS E-EVENINGS N=NIGHTS	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S
	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S	Shifts 200_ D/E/N 8 D/N 12 S M T W T F S

_______________________________________ ____________________

Signature of Program Director/Designee Date

NURSING STUDENT PLACEMENT COORDINATOR OF THE FACILITY

Please complete the following information to verify the availability for placement. Indicate yes or no to the following statements and provide additional information as requested.

____All placements specified in this document are currently unused and available

____Only the following placements specified in this document are currently unused and available: ______________________ ________

____The following placements are not available at this time but are anticipated to be available at the time of the student's clinical experience without displacing any other nursing students/program (provide breakdown): ________________________
____
____

____We could only place students in the following units if a program currently using the unit cancelled placements: _______
____
____
____

By signing this document I agree that the clinical placements offered in this document are available for the expected dates, and if they are not available as anticipated, I or another facility representative will assist the program in locating acceptable clinical placements.

______________________________	______________________	______________________
Name of Nursing Student Placement Coordinator	Title	Date
______________________________	______________________	______________________
Signature	Telephone Number	E-mail Address