CLINICAL AGENCIES

Copies of cooperating agency agreements must be included in your application and remain on file with the Arizona State Board of Nursing. *(Non-Facility Programs Only)*

Name of Agency:	Telephone:		Fax:
Type of Agency: ☐ Nursing Facility ☐ Hospital ☐ Medicare Certification Status ___________ ☐ Other___________			
Name of Contact Person:			
Facility Address:	City:	State:	Zipcode:

Name of Agency:	Telephone:		Fax:
Type of Agency: ☐ Nursing Facility ☐ Hospital ☐ Medicare Certification Status ___________ ☐ Other___________			
Name of Contact Person:			
Facility Address:	City:	State:	Zipcode:

Name of Agency:	Telephone:		Fax:
Type of Agency: ☐ Nursing Facility ☐ Hospital ☐ Medicare Certification Status ___________ ☐ Other___________			
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Facility Address:	City:	State:	Zipcode:

USE ADDITIONAL PAGES AS NEEDED