The Commonwealth of Massachusetts

Executive Office of Health and Human Services

Department of Public Health

250 Washington Street, Boston, MA 02108-4619



MAURA T. HEALEY

Governor

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Lieutenant Governor

KATHLEEN E. WALSH

Secretary

ROBERT GOLDSTEIN, MD, PhD Commissioner

**Tel: 617-624-6000**

**www.mass.gov/dph**

**244 CMR 6.05 Massachusetts Board of Nursing Petition for Nursing Education Programs offered by a parent institution that has a principal place of business outside of Massachusetts offering Clinical Experience in Massachusetts**

**Part B – Student Clinical Placement Information**

**Part A:** Submit one time at least 6 months prior to the start of any clinical experiences. Any changes to the Program information provided on this form must be updated within 7 days of such change.

**Part B: Submit 30 days prior to any student clinical placement**. A form must be completed for each clinical placement. Any changes must be updated within 7 days of change.

**Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Administrator Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Administrator Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Program Administrator Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Agency Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Written Agreement with Cooperating Agencies Utilized as Clinical Learning Site:**

**Written agreement is developed and reviewed annually by both the program and agency personnel 🞎**Yes **🞎**No

**Written agreement is current** **🞎**Yes **🞎**No

**Written agreement is specific in defining parameters of activities and responsibilities of the:**

**program** **🞎**Yes **🞎**No

**student** **🞎**Yes **🞎**No

**cooperating agency** **🞎**Yes **🞎**No

**Proposed Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Instructor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Instructor MA RN License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Highest Degree in Nursing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number of students in clinical group: \_\_\_\_\_\_\_**

**As CEO, I certify under the pains and penalties of perjury, that the information provided in this application is accurate.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** |  | **First Name** | **Title** |
|  |  |  | \_ |

**Signed:** **Date:**

**As Program Administrator, I certify under the pains and penalties of perjury, that the information provided in this application is accurate.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Last Name** |  | **First Name** | **Title** |
|  |  |  | \_ |

**Signed:** **Date:** \_\_\_