

UNIVERSITY OF ARIZONA

Affiliation /Preceptor Agreement Request Form for a "**PROGRAM**"

Prepared By: _____ Date: _____
College/Dept: _____ Phone: _____

PLEASE INITIATE: (check one)

- Affiliation Agreement – (Agreement with a site that is not mobile, i.e. Northwest Medical Center)
 Preceptor Agreement – (Agreement with one doctor in a Private Practice Clinic i.e. John Doe, M.D.)

Affiliate/Preceptor (Name & Degree if applicable): _____

Effective Date: _____

Site (Provide full legal site name & address including city, state, zip):

Learning Goals and Objectives (attach additional sheets if necessary):

Site Supervisor (Name & Degree): _____

Title: _____

Phone: _____ FAX: _____

Office contact (Name & phone, if applicable): _____

Email: _____

Authorized signatory for site: (Name & title) _____

APPROVALS:

By: _____ DATE: _____
Program Director/Department

Print Name: _____

GME Office _____ AHSC Contracting Office: _____

Completed a Minimum of 60 days in advance of 1st rotation

If applicable, Special Provisions have been sent electronically to dbigelow@u.arizona.edu and dvanover@email.arizona.edu if request is for an Affiliation Agreement.