LOUISIANA STATE BOARD OF NURSING

17373 PERKINS ROAD

BATON ROUGE, LOUISIANA 70810

COMMUNITY-BASED AGENCY REVIEW FORM

Directions: This form is to be used only for facilities utilized in which the student receives less than 10% of the total clinical experiences in a given course. Submit two (2) complete copies prior to completion of the educational term in which the experience took place. One copy will be returned for your records (3541.B.2)

I. NURSING PROGRAM DATA:

1. Parent Institution: Name _____

2. Nursing Education Program: Name _____

   Address_____

   City/State/Zip_____

3. Program Head: Name_____

   Title _____

4. Educational Term in which Experience

   took place: _____

5. Date Form Submitted to LSBN: _____

   month   day   year

II. COMMUNITY-BASED AGENCY DATA:

1. Agency: Name_____

   Address _____

   City/State/Zip_____

2. Administrator of Agency: Name_____

   Title_____

3. Nurse Administrator (if applicable): Name_____

   Title_____

4. Type of service rendered: (Full Service, Community Out-patient, Long-Term, Home Health, etc.)

   _____

5. Age group(s) served: _____

II.   COMMUNITY-BASED AGENCY DATA: (cont'd)

6.   Health Care Agencies - other than   Licensed by State of LA _____

        hospitals: (check all that apply)   Certified by HCFA _____

                                                    Accredited by JCAHO _____

                                                    Other_____

                                        --OR--

Non-Health Care Agency: §3542.F.

Sponsoring Agency: _____

7.   Course Number, Name and Credit Hours: _____

       Number of Credit Hours Allocated for: Theory_____   Clinical_____

                                                Theory and Clinical Ratio: _____

       Total number of Clinical Hours: _____

       Total number of Course Community-

       Based Hours per Student: _____

8.   Type of Learning Exercises Students

       Will be Experiencing: _____

                                                _____

                                                _____

9.   Responsible Party: _____ Faculty Member   _____ Preceptor

10.   Number of Students Assigned Per Rotation: _____

11.   Attach a list of any other nursing education program(s) utilizing the agency for student learning experiences at identical times including the type and number of students.

12.   A letter of agreement between the Nursing Education Program and the facility, that addresses the criteria in §3545 and biennial review is on file with the Education Program. (3529.D.)

       Yes _____   No _____   Pending _____   Date of Letter _____

                                        _____

                                        Signature of Program Head

                                        _____

                                        Title   Date

                                        OFFICE USE ONLY:

Document reviewed/approved by _____ Date_____

LSBN FORM N.E.6 (Revised, 4/96, 2012, 9/13/2016)