

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 completed form to scottt@lsbn.state.la.us for approval prior to completion of the educational term in which the experience took place. A 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: _____

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

6. Health Care Agencies - other than hospitals: (check all that apply) Licensed by State of LA _____ 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 _____