

Clinical Facility List BSN - Riverside

CLINICAL FACILITY	COURSE SUPPORTED	STUDENTS PER TERM	DAYS AND SHIFTS AVAILABLE	EDP	FACILITY AGREEMENT
Alhambra Hospital Medical Center	NUR2100C NUR2300C NUR3300C NUR4300C	20 20 20 20	7 days/week, 3 shifts/day	Yes	Yes
Anaheim Regional Medical Center	NUR2100C NUR2300C NUR3300C NUR3500C NUR4300C	30 30 30 5 30	2 days/week 3 shifts/day	Yes	Yes
Corona Regional Medical Center	NUR2100C NUR2300C NUR3300C NUR4300C	30 30 30 30	2 days/week 1 shift/week	Yes	In Process
Garfield Medical Center	NUR2100C NUR2300C NUR3300C NUR3500C NUR4300C	20 20 20 20	7 days/week, 2 shifts/day	Yes	Yes
Golden Legacy Care Center	NUR2100C NUR2300C NUR3300C	20 20 20	7 days/week, 2 shifts/day	Yes	In Process
Greater El Monte Community Hospital	NUR2100C NUR2300C NUR3300C NUR3600C NUR4300C	4 4 4 2 4	3 days/week 2 shifts/day	Yes	Yes

Clinical Facility List
BSN - Riverside

CLINICAL FACILITY	COURSE SUPPORTED	STUDENTS PER TERM	DAYS AND SHIFTS AVAILABLE	EDP	FACILITY AGREEMENT
Huntington Beach Hospital	NUR2100C NUR2200C NUR2300C NUR3300C NUR4300C NUR4600C	20 10 20 20 20 20	7 days/week 2 shifts/day	Yes	Yes
La Palma Intercommunity Hospital	NUR2100C NUR2300C NUR3300C NUR4300C	10 10 10 10	7 days/week, 2 shifts/day	Yes	Yes
Newport Children's Medical Group	NUR3600	NUR3600	6 days/week 1 shift/day	Yes	Yes
Palm Terrace Care Center	NUR2100C NUR2300C NUR3300C NUR4300C NUR4600C	10 10 10 10 10	7 days/week, 2 shifts/day	Yes	In Process
Parkview Community Hospital	NUR2100C NUR2300C NUR3300C NUR3500C NUR4300C	20 20 20 10 20	7 days/week, 3 shifts/day	Yes	Yes

Clinical Facility List
BSN - Riverside

CLINICAL FACILITY	COURSE SUPPORTED	STUDENTS PER TERM	DAYS AND SHIFTS AVAILABLE	EDP	FACILITY AGREEMENT
San Gabriel Valley Medical Center	NUR2100C NUR2200C NUR2300C NUR3300C NUR3500C NUR4300C NUR4600C	30 10 30 30 10 30 30	7 days/week 2 shifts/day	Yes	Yes
Santa Anita Convalescent Hospital	NUR2100C NUR2300C NUR3300C NUR4600C	30 30 30 20	7 days/week, 2 shifts/day	Yes	In Process
Sylmar Health and Rehabilitation Center	NUR2200C	20	7 days/week, 2 shifts/day	Yes	In Process
Villa Health Care Center	NUR2100C NUR2300C NUR3300C NUR4300C NUR4600C	10 10 10 10 10	7 days/week, 2 shifts/day	Yes	In Process
Whittier Hospital Medical Center	NUR2100C NUR2300C NUR3300C NUR3500C NUR3600C NUR4300C NUR4600C	20 20 20 10 10 20 20	7 days/week, 2 shifts/day	Yes	Yes

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with [CCR, title 16, section 1427](#) Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/18/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090

Name of Clinical Facility: Alhambra Hospital Medical Center	
Name of Chief Nursing Officer/Designee: Evelyn Ku	Phone: 626-458-4771
Email: eku@alhambrahospital.com	
Type of Clinical Facility: <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 100 S Raymond Ave, Alhambra, CA 91801	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input checked="" type="checkbox"/> Fundamentals-MS <input checked="" type="checkbox"/> Beginning-MS <input checked="" type="checkbox"/> Intermediate-MS <input checked="" type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	20				
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	60				

CLINICAL FACILITY INFORMATION	List specific units in the rows below (eg. 1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Medical-Surgical	20	<small>7 days a week/3 shifts per day</small>	3	20	600
2						
3						
4						
5						
6						
7						
8						
9						
10						

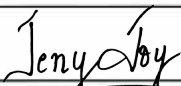
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	<i>2/12/21</i>
Signature of Clinical Facility's Liaison to Nursing Program	Date

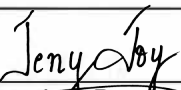
	2/18/21
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/18/21
Signature of Nursing Program Director/Designee	Date

For Board Use Only				
Approved	<input type="checkbox"/>			
Not Approved	<input type="checkbox"/>			
Cancelled	<input type="checkbox"/>	<table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">NEC Signature</td> <td style="width: 30%;">Date</td> </tr> </table>	NEC Signature	Date
NEC Signature	Date			
Reason(s) for Non-Approval:				

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

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PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date:

Nursing Program Name:	
Program Director/Designee:	Phone:

Name of Clinical Facility:	
Name of Chief Nursing Officer/Designee:	Phone:
Email:	
Type of Clinical Facility: <input type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address:	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input type="checkbox"/> Fundamentals-MS <input type="checkbox"/> Beginning-MS <input type="checkbox"/> Intermediate-MS <input type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G

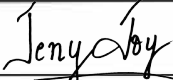
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

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Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.


Phyllis Snyder	Digitally signed by Phyllis Snyder Date: 2021.02.24 13:36:20 -08'00'	2/24/21
Signature of Clinical Facility's Liaison to Nursing Program		Date
		2/24/21
Signature of Nursing Program Director/Designee		Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

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- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
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The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/24/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
Cancelled <input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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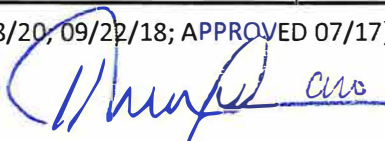
Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/2/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090

Name of Clinical Facility: Garfield Medical Center	
Name of Chief Nursing Officer/Designee: Herbert Villafuerte	Phone: 626-307-2000
Email: herbert.villafuerte@ahmchealth.com	
Type of Clinical Facility: <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 525 N. Garfield Ave, Monterey Park, CA 91754	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input checked="" type="checkbox"/> Fundamentals-MS <input checked="" type="checkbox"/> Beginning-MS <input checked="" type="checkbox"/> Intermediate-MS <input checked="" type="checkbox"/> Advanced-MS <input checked="" type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	20	20			
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	60	60			

CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)		Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Medical-Surgical	20	7 days/week, 2 shifts/day	6	30	400
2	Obstetrics	10	7 days/week, 2 shifts/day	4	16	200
3						
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6						
7						
8						
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10						

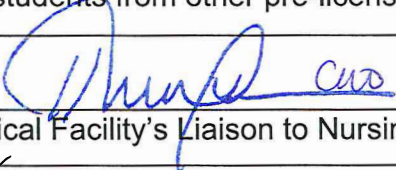
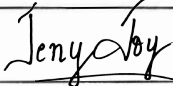

 Date: 02/22/21

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VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

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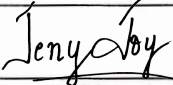
	02/22/21
Signature of Clinical Facility's Liaison to Nursing Program	Date
	2/22/21
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

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	2/22/21
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
Cancelled <input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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Nursing Program Name:	
Program Director/Designee:	Phone:

Name of Clinical Facility:	
Name of Chief Nursing Officer/Designee:	Phone:
Email:	
Type of Clinical Facility: <input type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address:	

CONTENT AREAS SUPPORTED					
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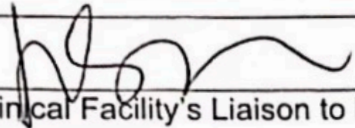
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4					
5					
6					
7					
8					
9					
10					

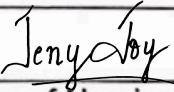
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VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

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Signature of Clinical Facility's Liaison to Nursing Program	Date

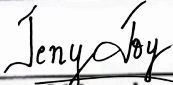
	2/18/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

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Signature of Nursing Program Director/Designee	Date

For Board Use Only

Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
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Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/19/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090

Name of Clinical Facility: Huntington Beach Hospital	
Name of Chief Nursing Officer/Designee: Patricia Cody, MBA, RN	Phone: 714-843-5000
Email: pcody@primehealthcare.com	
Type of Clinical Facility: <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 17772 Beach Blvd, Huntington Beach, CA 92647	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input checked="" type="checkbox"/> Fundamentals-MS <input checked="" type="checkbox"/> Beginning-MS <input checked="" type="checkbox"/> Intermediate-MS <input checked="" type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input checked="" type="checkbox"/> Psych/Mental Health <input checked="" type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	20			10	10
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	60			30	30

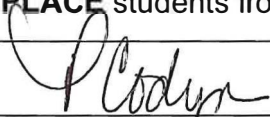
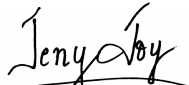
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg. 1 South, 2 South, Ortho, Rehab)		Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Medical-Surgical	10	7 days a week/2 shifts per day	5	16	200
2	Tele	10	7 days a week/2 shifts per day	5	16	200
3	Psych/Mental Health	10	7 days a week/2 shifts per day	5	18	200
4	Geriatrics	10	7 days a week/2 shifts per day	5	18	200
5						
6						
7						
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10						

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VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

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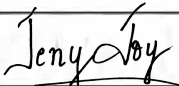
	2/25/21
Signature of Clinical Facility's Liaison to Nursing Program	Date
	2/19/21
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

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Cancelled	<input type="checkbox"/>	<table border="1" style="width: 100%;"> <tr> <td style="width: 70%;">NEC Signature</td> <td style="width: 30%;">Date</td> </tr> </table>	NEC Signature	Date
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Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/18/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090

Name of Clinical Facility: La Palma Intercommunity Hospital	
Name of Chief Nursing Officer/Designee: Hilda Manzo-Luna	Phone: 714-670-7400
Email: hmanzo-luna@primehealth.com	
Type of Clinical Facility: <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 7901 Walker St., La Palma, CA 90623	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input checked="" type="checkbox"/> Fundamentals-MS <input checked="" type="checkbox"/> Beginning-MS <input checked="" type="checkbox"/> Intermediate-MS <input checked="" type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	10				
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	30				

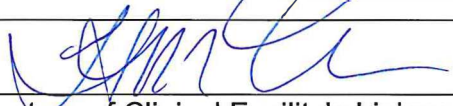
	CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Medical-Surgical	10	7 days per week/2 shifts per day	5	40	200
2						
3						
4						
5						
6						
7						
8						
9						
10						

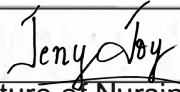
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	<i>2/22/2021</i>
Signature of Clinical Facility's Liaison to Nursing Program	Date

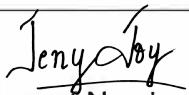
	2/18/21
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/18/21
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved	<input type="checkbox"/>	
Not Approved	<input type="checkbox"/>	
Cancelled	<input type="checkbox"/>	NEC Signature
Reason(s) for Non-Approval:		Date

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

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PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with CCR, title 16, section 1427 Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/23/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090

Name of Clinical Facility: Newport Children's Medical Group	
Name of Chief Nursing Officer/Designee: Zacharia Reda, MD	Phone: 949-644-0970
Email: maha.reda1@gmail.com	
Type of Clinical Facility: <input type="checkbox"/> Acute <input checked="" type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 1401 Avocado Ave. #802, Newport Beach, CA 92660	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input type="checkbox"/> Fundamentals-MS <input type="checkbox"/> Beginning-MS <input type="checkbox"/> Intermediate-MS <input type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input checked="" type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	PMH	G
			10		
Total number of annual student clinical placement needs per content area	MS	O	C	PMH	G
			30		

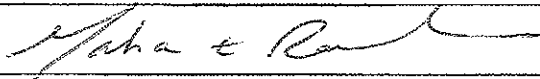
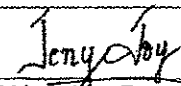
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg. 1 South, 2 South, Ortho, Rehab)		Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Pediatrics	10	5 days per week/1 shift per day	1	50	100
2						
3						
4						
5						
6						
7						
8						
9						
10						

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
 (Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

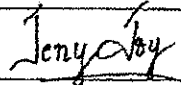
	2/24/21
Signature of Clinical Facility's Liaison to Nursing Program	Date
	2/23/21
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/23/21
Signature of Nursing Program Director/Designee	Date

For Board Use Only	
Approved <input type="checkbox"/>	
Not Approved <input type="checkbox"/>	
Cancelled <input type="checkbox"/>	NEC Signature
Reason(s) for Non-Approval:	
Date	

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

[Handwritten Signature] 2/24/21

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with [CCR, title 16, section 1427](#) Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date:

Nursing Program Name:	
Program Director/Designee:	Phone:

Name of Clinical Facility:	
Name of Chief Nursing Officer/Designee:	Phone:
Email:	
Type of Clinical Facility: <input type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address:	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input type="checkbox"/> Fundamentals-MS <input type="checkbox"/> Beginning-MS <input type="checkbox"/> Intermediate-MS <input type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G

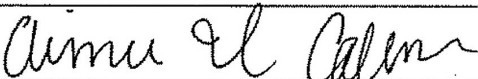
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

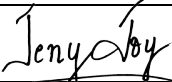
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	2/19/2021
Signature of Clinical Facility's Liaison to Nursing Program	Date

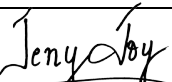
	2/22/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/22/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
Cancelled <input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

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PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with [CCR, title 16, section 1427](#) Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/2/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090
Name of Clinical Facility: Parkview Community Hospital	
Name of Chief Nursing Officer/Designee: Julie Curtis	Phone: 951-688-2211
Email: julie.curtis@ahmchealth.com	
Type of Clinical Facility: <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 3865 Jackson St., Riverside, CA 92503	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical:	<input checked="" type="checkbox"/> Fundamentals-MS	<input checked="" type="checkbox"/> Beginning-MS	<input checked="" type="checkbox"/> Intermediate-MS	<input checked="" type="checkbox"/> Advanced-MS	
	<input checked="" type="checkbox"/> Obstetrics	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Psych/Mental Health	<input type="checkbox"/> Geriatrics	
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	20	10			
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	60	30			

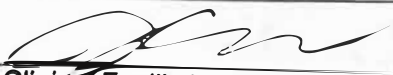
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)		Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	2nd Floor	7	7 days/week, 3 shifts/day	9	25	210
2	C Wing	7	7 days/week, 3 shifts/day	8	25	210
3	3rd Floor	6	7 days/week, 3 shifts/day	6	20	180
4	Labor and Delivery	4	7 days/week, 3 shifts/day	5	10	120
5	Mother Baby	4	7 days/week, 3 shifts/day	5	5	120
6	NICU	2	7 days/week, 3 shifts/day	3	5	60
7						
8						
9						
10						

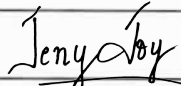
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	2/12/21
Signature of Clinical Facility's Liaison to Nursing Program	Date

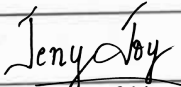
	2/16/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/16/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only			
Approved	<input type="checkbox"/>		
Not Approved	<input type="checkbox"/>		
Cancelled	<input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:			

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with CCR, title 16, section 1427 Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/4/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Minerva Valdenor	Phone: 949-794-9090

Name of Clinical Facility: San Gabriel Valley Medical Center	
Name of Chief Nursing Officer/Designee: Edgar Solis	Phone: 626-570-6571
Email: edgar.solis@ahmchealth.com	
Type of Clinical Facility: <input checked="" type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address: 438 W. Las Tunas Dr., San Gabriel, CA 91776	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input checked="" type="checkbox"/> Fundamentals-MS <input checked="" type="checkbox"/> Beginning-MS <input checked="" type="checkbox"/> Intermediate-MS <input checked="" type="checkbox"/> Advanced-MS <input checked="" type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input checked="" type="checkbox"/> Psych/Mental Health <input checked="" type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	30	10		10	10
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	150	30		30	30


	CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Medical-Surgical	20	7 days/week, 2 shifts/day	8	40	400
2	Obstetrics	10	7 days/week, 2 shifts/day	6	12	200
3	Psych/Mental Health	10	7 days/week, 2 shifts/day	6	30	200
4	Geriatrics	10	7 days/week, 2 shifts/day	6		200
5						
6						
7						
8						
9						
10						

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	2/15/21
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Signature of Clinical Facility's Liaison to Nursing Program

Date

	2/16/2021
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Signature of Nursing Program Director/Designee

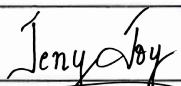
Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
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- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/16/2021
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Signature of Nursing Program Director/Designee

Date

For Board Use Only		
Approved	<input type="checkbox"/>	
Not Approved	<input type="checkbox"/>	
Cancelled	<input type="checkbox"/>	NEC Signature
		Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with [CCR, title 16, section 1427](#) Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date:

Nursing Program Name:	
Program Director/Designee:	Phone:

Name of Clinical Facility:	
Name of Chief Nursing Officer/Designee:	Phone:
Email:	
Type of Clinical Facility: <input type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address:	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input type="checkbox"/> Fundamentals-MS <input type="checkbox"/> Beginning-MS <input type="checkbox"/> Intermediate-MS <input type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G

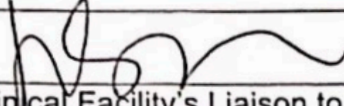
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

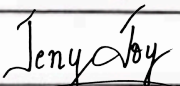
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	2/18/2021
Signature of Clinical Facility's Liaison to Nursing Program	Date

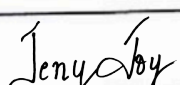
	2/18/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
- Contract/Affiliation Agreement is established, signed, and filed.
- Plan for continued communication between school and facility approved and on file (i.e., Instructor/Faculty Staff Meeting, Agency/Faculty Student Meeting each semester, Annual Faculty/Facility Staff Meeting, Dean/Director Conference each semester).

The requested information on this form and requirements for starting in a new clinical facility are verified by the Nursing Program Director/Designee.

	2/18/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only

Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
Cancelled <input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

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PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

Consistent with [CCR, title 16, section 1427](#) Clinical Facilities, (a) A nursing program shall not utilize any agency or facility for clinical experience without prior approval by the board. Each program must submit evidence that it has complied with the requirements of subdivisions (b), (c), and (d) of this section and the policies outlined by the board.

Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date:

Nursing Program Name:	
Program Director/Designee:	Phone:

Name of Clinical Facility:	
Name of Chief Nursing Officer/Designee:	Phone:
Email:	
Type of Clinical Facility: <input type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address:	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input type="checkbox"/> Fundamentals-MS <input type="checkbox"/> Beginning-MS <input type="checkbox"/> Intermediate-MS <input type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G

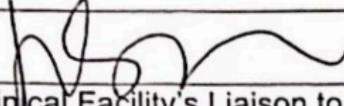
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

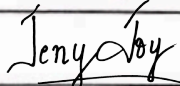
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
(Submit forms electronically)

VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

Note: CCR, title 16, section 1427(d) states "In selecting a new clinical agency or facility for student placement, the program shall take into consideration the impact that an additional group of students would have on students of other nursing programs already assigned to the agency or facility."

Each signature below verifies that use of this clinical facility by the requesting nursing program **WILL NOT DISPLACE** students from other pre-licensure nursing programs.

	2/18/2021
Signature of Clinical Facility's Liaison to Nursing Program	Date

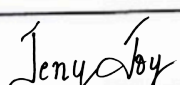
	2/18/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
- Assurance that staff is adequate in number and quality to ensure safe and continuous health care services to patients;
- Provisions for continuing communication between the facility and the program; and
- A description of the responsibilities of faculty assigned to the facility utilized by the program.
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	2/18/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
Cancelled <input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date:

Nursing Program Name:	
Program Director/Designee:	Phone:

Name of Clinical Facility:	
Name of Chief Nursing Officer/Designee:	Phone:
Email:	
Type of Clinical Facility: <input type="checkbox"/> Acute <input type="checkbox"/> Non-Acute <input type="checkbox"/> Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Telehealth <input type="checkbox"/> Ambulatory Care <input type="checkbox"/> Non-Healthcare	
Clinical Facility Address:	

CONTENT AREAS SUPPORTED					
Place X in the appropriate area(s).					
Medical Surgical: <input type="checkbox"/> Fundamentals-MS <input type="checkbox"/> Beginning-MS <input type="checkbox"/> Intermediate-MS <input type="checkbox"/> Advanced-MS <input type="checkbox"/> Obstetrics <input type="checkbox"/> Pediatrics <input type="checkbox"/> Psych/Mental Health <input type="checkbox"/> Geriatrics					
Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G

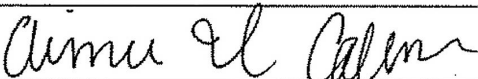
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg.1 South, 2 South, Ortho, Rehab)	Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

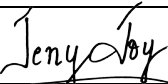
PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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VERIFICATION OF NONDISPLACEMENT OF OTHER PRE-LICENSURE PROGRAM STUDENTS

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	2/19/2021
Signature of Clinical Facility's Liaison to Nursing Program	Date

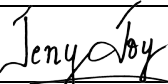
	2/22/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

Checklist for starting in a new clinical facility: (Place an X next to completed requirements.)

- Assurance of the availability and appropriateness of the learning environment in relation to the program's written objectives;
- Provision for orientation of faculty and students;
- A specification of the responsibilities and authority of the facility's staff as related to the program and to the educational experience of the students;
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	2/22/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved <input type="checkbox"/>		
Not Approved <input type="checkbox"/>		
Cancelled <input type="checkbox"/>	NEC Signature	Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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Clinical Agency/Facility Cancellation (complete top two (2) sections only). Date: 2/3/21

Nursing Program Name: Stanbridge University, Riverside Campus	
Program Director/Designee: Dr. Jeny Joy	Phone: 949-794-9090

Name of Clinical Facility: Whittier Hospital Medical Center	
Name of Chief Nursing Officer/Designee: Sarkis Vartanian	Phone: 562-464-2992

Email: sarkis.vartanian@ahmchealth.com

Type of Clinical Facility: Acute Non-Acute Long-Term Care Clinic Telehealth
 Ambulatory Care Non-Healthcare

Clinical Facility Address: 9080 Colima Rd, Whittier, CA 90605

CONTENT AREAS SUPPORTED
Place X in the appropriate area(s).

Medical Surgical: Fundamentals-MS Beginning-MS Intermediate-MS Advanced-MS
 Obstetrics Pediatrics Psych/Mental Health Geriatrics

Number of student placements needed for Quarter/Semester per content area	MS	O	C	P/MH	G
	20	10	10		10
Total number of annual student clinical placement needs per content area	MS	O	C	P/MH	G
	60	30	30		30

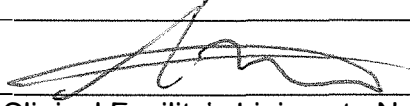
CLINICAL FACILITY INFORMATION List specific units in the rows below (eg. 1 South, 2 South, Ortho, Rehab)		Number of Students on Unit	Days and Shifts Currently Available	Average RN Staffing	Average Daily Census	Annual Student Clinical Capacity per Unit
1	Medical-Surgical	20	7 days/week, 2 shifts/day	7	20	400
2	Obstetrics	10	7 days/week, 2 shifts/day	8	15	200
3	Pediatrics	10	7 days/week, 2 shifts/day	1	18	200
4	Geriatrics	10	7 days/week, 2 shifts/day	15	30	200
5						
6						
7						
8						
9						
10						

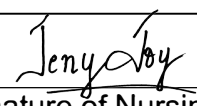
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	2/12/21
Signature of Clinical Facility's Liaison to Nursing Program	Date

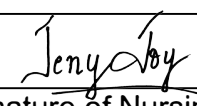
	2/16/2021
Signature of Nursing Program Director/Designee	Date

VERIFICATION OF INFORMATION AND RESPONSIBILITIES

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	2/16/2021
Signature of Nursing Program Director/Designee	Date

For Board Use Only		
Approved	<input type="checkbox"/>	
Not Approved	<input type="checkbox"/>	
Cancelled	<input type="checkbox"/>	NEC Signature
		Date
Reason(s) for Non-Approval:		

PROGRAM CLINICAL FACILITY AUTHORIZATION FORM
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