Clinical Affiliate Spread Sheet

Program Name: _____   Program Number: _____   Date: _____

Instructions: Please complete all columns. List all clinical sites, including separate locations within a site.

	Name of Clinical Affiliate	Specialties used at this rotation. List all that apply: AB, OB/GYN, V, C	Name of Clinical Instructor	Credentials for designated CI (For accepted CI credentials see Policy 5.17)
1				
2				
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20				

For Additional Affiliates add lines as necessary

_____   _____

Program Director Signature   **Date**

The JRC-DMS will not accept any Clinical Affiliate Spreadsheet that does not include the program director signature.