**University of Nebraska Medical Center**

**College of Nursing**

**Clinical Associate or Volunteer Faculty Annual Review**

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| --- |
| Name (of Clinical Associate or Volunteer Faculty): |
| Position / Title: |
| Agency Name: |
| Agency Address: |
| E-mail Address: |  | Cell #: |  |
| Work Telephone: |  | Home Telephone: |  |
|  |
| RN Nebraska License #: |  | APRN License #: |  |
| RN Expiration Date: |  | APRN Expiration Date: |  |
| CON Division/Department this person resides in: |  | Certification (Type): |  |
|  |
| Faculty Recommendation(Signature): |  | Date: |
| (Check one box): |  | Continue Appointment |  | Discontinue Appointment |
|  |
| Department Chair or Assistant Dean (Signature): |  | Date: |
|  |
| See Policy 4.4.4 for information about Clinical Associate, Senior Clinical Associate & Volunteer Faculty Appointments. Please return this completed form along with an updated CV to LaDonna Tworek in the Dean’s Office. |