**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. | | | | | | |