

Clinical Affiliation Information Form

_____, student/applicant to the SBB program by distance education, requires a clinical affiliation. Please complete the following and send this with the affiliation agreement to Janet Vincent, Education Coordinator at UTMB.

Name of facility: _____

Address: _____

City _____ State: _____ Zip _____

Name of contact person or person completing this form: _____

Title: _____

Please indicate which of the following is performed at your facility:

	yes	no
Transfusion preparation for surgical patients	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion preparation for Labor and Delivery Patients	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion preparation for neonates	<input type="checkbox"/>	<input type="checkbox"/>
Transfusion preparation for oncology patients	<input type="checkbox"/>	<input type="checkbox"/>

Note: Transfusion preparation means type and screens, crossmatch, providing components, etc.

	yes	no	Approximate procedures per year										
Antibody Identification	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>										
Cord Blood	<input type="checkbox"/>	<input type="checkbox"/>											
DAT	<input type="checkbox"/>	<input type="checkbox"/>											
Elutions	<input type="checkbox"/>	<input type="checkbox"/>											
Absorptions	<input type="checkbox"/>	<input type="checkbox"/>											
Donor drawing	<input type="checkbox"/>	<input type="checkbox"/>											
Apheresis procedures	<input type="checkbox"/>	<input type="checkbox"/>											
Therapeutic Procedures	<input type="checkbox"/>	<input type="checkbox"/>											
Component preparation*	<input type="checkbox"/>	<input type="checkbox"/>											
Frozen Red blood Cells	<input type="checkbox"/>	<input type="checkbox"/>											

* Please provide annual statistics for different components

	yes	no
processing of blood and blood products	<input type="checkbox"/>	<input type="checkbox"/>
Labeling of blood and blood products	<input type="checkbox"/>	<input type="checkbox"/>
Viral Marker Testing/Transmissible diseases	<input type="checkbox"/>	<input type="checkbox"/>
Bone Marrow Transplantations	<input type="checkbox"/>	<input type="checkbox"/>

This facility is accredited/Licensed by: (circle all that apply) AABB CAP JCAHO FDA

Name the computer system used : _____

- | | | |
|---|-----|----|
| Would you and/or your staff be willing to listen and evaluate the student for oral presentations? | yes | no |
| Would you and/or your staff be willing to discuss policies and procedures with the student? | yes | no |
| Would you be able to allow the student the use of equipment and/or reagents? | yes | no |
| Does your facility have a committee that approves research projects? | yes | no |
| Would the facility require the student to pay for any services/reagents provided? | yes | no |

If the answer is yes, please list the items you would expect the student to pay for and/or the amount of money expected for services provided: