AUGUSTA UNIVERSITY

AU Health Professions Associates

Request-to-Practice Form

Date:

Name of Faculty or Credentialed Staff (include credentials as they should appear on contract):		
Last:	First:	Credential(s):
Department:		
Campus Address:	Campus Phone:	

Organization Information		
Legal name of the organization receiving the proposed professional services:		
Address:		
City:	State:	Zip:

Contact Person at the Organization	
Name:	Title:
Phone:	e-mail:

Description of Activity

Category of proposed activity (check all that apply):

Clinical practice □	Consultation □
Continuing education/presentation/education □	Other □

Describe the specific professional services to be provided to the above organization:

Estimate the frequency of proposed professional services:
% faculty effort allocated for clinical practice:

Indicate the anticipated period of time to be covered by a contract:

Indicate the income anticipated for the delivery of proposed professional services:

Describe travel or other expenses that will be covered by the organization receiving the professional services:

The appropriate credential/license/registration/certification is in good standing for this faculty to provide the professional services in the jurisdiction described above.	☐ Yes ☐ No

CAHS Signatures	
Faculty Signature:	Date:
Chair Signature:	Date:

Please send the completed form to Stephanie Johnson, AUHPA@augusta.edu.

Chief Administrator, AUHPA

☐ Approved for Practice
☐ Recommended for Outside Activity
☐ Other:

Signature:	Date: