Clinical Faculty and Preceptor Information Form

For School of Nursing Contract File

This form must be completed by the student and approved by the instructor before agreement can be initiated.

Student Name: _____

Name of Preceptor: _____

Name of Facility: _____

Address of Preceptor Facility:

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

Facility Administrator: _____

Name of Collaborating Physician (if APRN): _____

Name of Faculty Member Requesting Facility/Preceptor: _____

Designation of level of students who will be using facility:

- ☐ BSN-MSN
- ☐ BSN-DNP
- ☐ MSN-DNP

*Preceptor State License Number: _____

State of License: _____

*Notation: Preceptor and student must be licensed in state of clinical experience.

All individuals must submit a curriculum vitae (resume).

Students: Do not write in the section below.

Date submitted to department: _____

Approved by: _____

Instructor Signature: _____