UNIVERSITY OF CONNECTICUT
SCHOOL OF NURSING

Nomination Form
CLINICAL ASSOCIATE/PRECEPTOR

* If contact information is unchanged from previous appointment, check here _____

Name & Title _____Credentials_____

Academic/Clinical Affiliation:_____

Address: Street_____

Town_____State_____Zip_____

email_____ Phone # (day)_____

SSN_____

is re-nominated ___nominated _____for the position of Clinical Associate for the following contribution(s) to the University of Connecticut School of Nursing:

Undergraduate Curriculum	Graduate Curriculum
Clinical Preceptor_____	Clinical Preceptor_____
Guest Lecturer _____	Guest Lecturer _____
Agency Liaison _____	Agency Liaison _____
Other _____	Other _____

Other Contributions:_____

_____

_____

_____

Faculty Members Nominating:_____ Date:_____

(2 faculty members required) _____ Date:_____

Current c.v. _____

Nominee Accepts _____Decline _____nomination

Date of appointment:_____ Level of appointment: _____ Renewal date: _____

Revised 9/29/03
Updated 3/2/10 oke