Information needed for preceptorships

Please provide all information requested in order to ensure the letter sent to your preceptor and contract to owner are accurate. *Please provide ALL information.*

Student's name:_____

Student's address_____

Phone number:_____Email address:_____

PRACTICE & PRECEPTOR INFO:

Name of Practice: _____

Owner of Practice_____

Practice Contact Person Phone: _____ Email: _____

Preceptor's first name:_____Last name:_____

Credentials: MD__ PA__ ANP__ AGPCNP__ ACNP__ AGACNP__ CNM___ FNP__

Certifier: AACN_____ANCC: _____AANP-CB_____

Street Address:_____ Suite #:_____

City/town: _____State: _____ Zip code: _____

Preceptor's telephone number: _____ **REQUIRED** Email address:_____

Preceptor's preferred method of Contact from Faculty: _____

Dates of preceptorship:_____ Semester (Please circle): Spring Fall

Number of hours per week or total for site:_____Days & times at Site_____

Please answer the following questions to ensure the correct information is provided to your preceptor.

Which NP specialty track you are in (Please circle): Adult Acute Family

The practicum course name:_____Course number: _____

Faculty overseeing your preceptorship (Graduate Track Director):_____

Contact Person for Contracts: (ex. Office Manager)

Name: _____ Tel. #:

Title: ___ E-mail:

Signatory Name (if known):
_____

Signatory Title (if known):
_____

Once complete please return to your respective Graduate Track Director