PennState College of Nursing

THE PENNSYLVANIA STATE UNIVERSITY

COLLEGE OF NURSING

PRECEPTOR AGREEMENT FORM

Form Instructions: <u>This form needs to be print-filled and NOT pen-filled.</u> Student will complete the first part. Preceptor will complete and sign the second part. The completed form should be returned to the clinical faculty (by the student) for final signature. A completed copy will be given to the preceptor and the agency. The student will upload into the course via CANVAS.

Date: ____________________ Semester: ______________ Year: _________ Course: ________

Student's Name: ____

Student Tel #: ___________________________ Student PSU E-mail: ________________________________

Clinical Faculty Name: ____

Clinical Faculty Email: ___________________________ Clinical Faculty Phone: ______________________

Physician (MD/DO) / Preceptor Information (To be completed by Preceptor):

PRECEPTOR NAME & CREDENTAILS: ____

E-mail: __________________________ Clinical Specialty Area: __________________ Years in Advanced Role: ______

# of students you are concurrently supervising per day: ______ # of students you are precepting per Semester: _____

Pennsylvania MD/DO/CRNP#: ____________________ Academic Degrees (indicate nursing): __________________

Agency/Clinical Practice Name: ____

Agency/Clinical Address: ____

Agency/Clinical City: ______________ Agency/Clinical State: ________________ Agency/Clinical Zip Code: _________

Agency/Clinical Telephone # ________________________ Agency/Clinical Fax #: ________________________

Accreditation Status (if applicable): ____

Clinical Agency Type

- ☐ Birthing Center
- ☐ Community Health Center
- ☐ Federal and State Bureaus of prison
- ☐ Health Department Clinic (state, county or city)
- ☐ Home Health
- ☐ Hospice
- ☐ Hospital (community)
- ☐ Hospital (federal)
- ☐ Hospital (private)
- ☐ Long Term Care Facility
- ☐ Nurse Managed Health Clinic
- ☐ Private Practice
- ☐ Rural Health Clinic
- ☐ School Based Health Center
- ☐ Other ________________

Clinical Setting

- [ ] Federally Qualified Health Center
- [ ] Health Professional Shortage Area
- [ ] Medically Underserved Communities
- [ ] Rural Location

Experience to be provided

- [ ] Family
- [ ] Pediatrics
- [ ] Older Adults
- [ ] Women's Health
- [ ] Other ______________________________

Patient Types (List all that apply)

- [ ] Acute
- [ ] Chronic
- [ ] Ambulatory
- [ ] In-Hospital
- [ ] Out-Patient
- [ ] Other ______________________

Faculty Accreditation

Yes No

REQUIRED SIGNATURES

Preceptor: ____ Date: __________________

Clinical Faculty: ____ Date: __________________

COURSE SYLLABUS TO BE GIVEN TO PRECEPTOR along with a copy of this form.

Program Contact Information:

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