**Penn State College of Nursing**

**Preceptor Information Form**

**Course**: \_\_\_\_\_\_\_\_\_\_ **Semester**: \_\_\_\_\_\_\_\_\_\_\_\_

**Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRECEPTOR INFORMATION**

|  |  |
| --- | --- |
| Preceptor Name |  |
| RN License #/ State |  |
| Title/Position |  |
| Place of Employment |  |
| Employer’s Address |  |
| Manager’s Name and Phone Number |  |

**CONTACT INFORMATION**

|  |  |
| --- | --- |
| Preferred **Mailing Address**: |  |
| Telephone Number: |  |
| **Email Address:**  *(an email that you check* ***often*** *or daily)* |  |
| Preferred method of contact  *(please indicate* ***✓*** *)* | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CERTIFICATIONS**

|  |  |
| --- | --- |
| Name of Certification(s)/Expiration Date |  |
|  |  |

**PROFESSIONAL MEMBERSHIPS**

|  |  |
| --- | --- |
| Name of Organization(s) |  |
|  |  |

**EDUCATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Degree | Year Graduated | School/Program | Address/Location |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**WORK EXPERIENCE**

|  |  |  |
| --- | --- | --- |
| **Work Experience (Please include all related experience):**  *Total years of experience as a Registered Nurse: \_\_\_\_\_*  *Years of Experience as: \_\_\_\_\_*Staff Nurse; \_\_\_\_\_\_ Charge Nurse; \_\_\_\_\_\_Team Leader; \_\_\_\_\_ Nurse Manager; \_\_\_\_\_ Other Leadership Role \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Years of Experience in Nursing Specialty:*  \_\_\_\_\_ Med-Surg; \_\_\_\_ Telemetry; \_\_\_\_ Critical Care\_\_\_\_\_ L&D; \_\_\_\_ Pediatrics; \_\_\_\_\_ NICU; \_\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Dates | Position Held | Employer’s Name and Address/Location |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**CLINICAL AGENCY INFORMATION**

|  |  |
| --- | --- |
| Name of Organization(s) | Address of Organization |
| Contact Person Name | Contact Person Email Address |
| Area to be used for clinical experience |  |

**SIGNATURES:**

Student:

I request the College of Nursing’s approval for a clinical experience with the above instructor and agency.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preceptor:

I agree that the information provided above is true to the best of my knowledge. I agree to provide a precepted clinical experience at the above agency for this student.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For RN to BSN Program Only:***

Instructor:

I approve this student’s experience with the preceptor and agency designated above.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 2/25/20