RCCC

APSU ETSU MTSU TSU TTU UOM

Master's of Science in Nursing
PRECEPTORSHIP REQUEST FORM

Date: _____ **Course Number:** _____ **Course Title:** _____ **Home School:** _____

Semester *(Circle)*: **Fall** **Spring** **Summer** **Year:** _____

Concentration *(Circle)*: **Administration** **Education** **FNP** **Informatics** **Post Master's?: Yes**_____ **No**_____

Please Print Legibly. Incomplete or Illegible forms will *significantly* delay process.

STUDENT INFORMATION: **Are you a RODP Student? *(Circle)* YES or NO**

First Name: _____ Middle Initial: _____ Last Name: _____

Day Phone: _____ Alternate Phone: _____ Personal Email: _____ School Email _____

CLINICAL PRACTICUM SITE AND AFFILIATION AGREEMENT INITIATION INFORMATION: ***(Your place of employment cannot be your preceptor site)***

Site Name (FULL name, not initials): _____

Site Street Address: _____

Site City: _____ State: _____ Zip: _____ County: _____

Name of Parent Agency *(if Site is owned or managed by a parent company)*: _____

**** Person Responsible for Contract Management at this Site or at Parent Agency**** *(Required Information)*

First Name: _____ Last Name: _____

Phone: _____ Fax: _____ Email: _____

PRECEPTOR INFORMATION ***A separate Preceptor Request Form must be submitted for each preceptor and/or site.***

First Name: _____ Last Name: _____ Phone:(____)_____ Email:_____

Years of experience as a practitioner: _____ Number of students concurrently being precepted by you this semester:_____

EDUCATION *(check all that apply)*:

MSN: _____ DNP: _____ PhD (*Nursing*): _____ MD: _____ DO: _____ PA ____ Masters (*other*): _____ Doctorate (*other):* _____

LICENSURE:

RN License No: _____ State: _____ Expiration Date: _____ Specialty:_____

APN License No: _____ State: _____ Expiration Date: _____ Specialty:_____

MD/DO/PA License No: _____ State: _____ Expiration Date: _____ Specialty:_____

Certification Type: _____ Certifying Body:_____ Expiration Date:_____

CLIENT POPULATION:

Information about the Clinical Site Listed above		SPECIALTY	Information about the Preceptor's practice at this site	
To the **right** is a list of types of patients or clinical experiences that may be available for students at the clinical site listed above. Please check any and all that apply to your clinical site. This information will help future students search and find sites that offer the type of patient or experience they need. Thank You!	❑	Administration	_____%	To the **left**, please estimate the percent of time that the above preceptor spends with each type of patient or clinical experience at the site listed above. This information will help future students search and find preceptors that offer the type of patient or experience they need. Thank You!
	❑	Adolescent	_____%	
	❑	Adult	_____%	
	❑	Education	_____%	
	❑	Family Practice	_____%	
	❑	Geriatrics	_____%	
	❑	GYN/OB	_____%	
	❑	Gynecology	_____%	
	❑	Informatics	_____%	
	❑	Obstetrics	_____%	
	❑	Pediatrics	_____%	

I agree to serve as a preceptor for _____ (student name). I have read the preceptor responsibilities and accept the roles and responsibilities therein. ***Preceptor, please return this form to student for applicable processing****

***Signature:** _____ **Printed Name:** _____ **Date:** _____

STUDENT: Thank you for FAXING this form to 615-366-3953 or EMAIL to msnclinicalforms@tbr.edu ***ONE METHOD ONLY***

***Student Signature:** _____ **Printed Name:** _____ **Date:** _____ Rev: January 15, 2013

***(Unsigned forms will not be accepted)**