Student Please Complete

Please complete the top portion of this form and then deliver to your preceptor/clinical mentor to complete. Students cannot begin a clinical experience until this form is completed and signed by their preceptor/clinical mentor and returned to the College of Nursing.

Identify your program of study:  
- ☐ BSN Baccalaureate
- ☐ RN/BSN Associates to Baccalaureate
- ☐ MSN Clinical Nurse Leader
- ☐ MSN Advanced Practice RN
- ☐ MSN Nurse Educator
- ☐ MSN APRN & Nurse Educator Certificate
- ☐ MSN to Doctorate
- ☐ BSN to Doctorate

Course Number and Title: ____________________________________________________________

Clinical Faculty (Instructor): ______________________________________________________

Total Number of Clinical Hours: ____________________________ Term: ☐ Fall ☐ Spring ☐ Summer ☐ Year:

________________________________________  ______________________________  ______
Student Name (Required Print)  Signature  Date

You may sign this completed portion of the form with your electronic signature by clicking on the box here ☐.

Preceptor/Clinical Mentor Please Complete and Return to Student

Dear Preceptor or Clinical Mentor,

Please fill out this initial information form completely and list the email address you would like the College of Nursing to send your official Clinical Agreement. The e-mail address and phone number you list are your preferred contact locations and where we are most likely to reach you. The official Clinical Agreement will be sent to the email address you provide below and must be completed and submitted online before you can precept/mentor the student in the clinical setting.

Full Name as it appears on professional license: ____________________________________________

Credentials: ____________________________________________ Total Number of Clinical Hours: ____________

Email Address: ____________________________________________

Name of Clinical Experience Location: ______________________________________________________

Address: ____________________________________________________________

City: ____________________________ State: ____________ Zip code: ____________________________

Phone: ____________________________

I have a copy of the Preceptor Guidelines, and agree that I meet the guidelines by years of practice and clinical expertise and experience. I agree to complete the electronic version of the preceptor information form. I understand that I will receive course and student evaluation materials from the course coordinator and students with whom I have agreed to precept. I understand there is no remuneration or fringe benefits attached to this role.

You may sign this completed form with your electronic signature by clicking on the box here ☐ and e-mail your information to appropriate program support staff listed below.

________________________________________  ______________________________  ______
Preceptor/Clinical Mentor Signature  Date

FOR COLLEGE OF NURSING USE ONLY

Typhon  ____________________________  Survey sent  ____________________________  Active contract  ____________________________
Qualtrics  ____________________________  License  ____________________________  Green light given  ____________________________

Revised 6/1/15