APSU ETSU MTSU TSU TTU UOM

Urgent Notice

EFFECTIVE JANUARY 2017 ALL REQUEST MUST BE SUBMITTED VIA EMAIL & MEDATRAX PER INSTRUCTIONS BELOW

TN eCampus

Master of Science in Nursing ~ PRECEPTORSHIP REQUEST FORM

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

Semester: **Year:** **Concentration:** **Post Master's?: Yes___ No___**

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

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

First Name: _____ Last Name: _____ Day Phone: _____

Alternate Phone: _____ School Email: _____ Personal Email (required) _____

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

Site Name (FULL name, not initials): _____ Site Phone: _____

Site Street Address: _____

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

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

Contract Contact Name: _____

Phone: _____ Fax: _____ Email: _____

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

PRECEPTOR INFORMATION ***A Copy of Preceptor's CV/Resume' is REQUIRED. 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: _____

Approximate number of clinical hours you plan to spend with this preceptor: _____

EDUCATION *(check all that apply)*:

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

LICENSURE: *A copy of Preceptor's license is **REQUIRED** or student may visit appropriate state licensure verification website, print license status page and submit along with this form.*

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	_____%
	❑	Adolescent	_____%
	❑	Adult	_____%
	❑	Education	_____%
	❑	Family Practice	_____%
	❑	Geriatrics	_____%
	❑	GYN/OB	_____%
	❑	Gynecology	_____%
	❑	Informatics	_____%
	❑	Obstetrics	_____%
	❑	Pediatrics	_____%

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!

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 along with a copy of your CV/Resume' and license to student for processing****

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

STUDENT: ALL requests must be uploaded via Medatrax Mail Center and emailed to msnclinicalforms@tbr.edu ***BOTH METHODS are REQUIRED***

***Student Signature:** _____ **Printed Name:** _____ **Date:** _____ *December 16, 2016*

***(Unsigned forms will not be accepted)** Z:\RODP\NURSING & ALLIED HEALTH\MASTER OF SCIENCE IN NURSING\PRECEPTORSHIP PROCESS\Preceptorship FORMS\2016 TN eCampus Forms\PreceptorshipRequestFormJan2017