Thank you for agreeing to precept an FAU Graduate Student. Please complete the following form. Detailed information for preceptors including information on tuition waivers is provided on the College of Nursing Website.

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| Name of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preceptor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_Office Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred Method of Contact: € Phone € e-mail  Credentials: € MD € DO € NP  Other\_\_\_\_\_ Professional License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Highest degree held: € Master’s € DNP € PhD € MD € DO  State Issuing License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  National Certification(s) held: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPs: € ANCC € AANP  MD or DO Specialty Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years of Experience in Specialty: \_\_\_\_\_\_\_\_  College or University Degrees and Dates Awarded: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **This Section to be Completed by Student:**  I Agree to Precept (Student Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Student’s FAU e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Course Number and Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Semester: € Fall € Spring  Summer Year: \_\_\_\_\_\_\_\_Hours to be Completed:\_\_\_\_\_\_\_\_\_\_  FAU Supervising Clinical Faculty Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Faculty Contact Information Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | | --- | | **Preceptor’s Signature: Date:** |   NP Concentration Coordinator Tracian Kelly, DNP, FNP-BC, PMHNP-BC  [TKelly11@health.fau.edu](mailto:TKelly11@health.fau.edu). Cell 305 753-3031 |