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-mailCredentials: € MD € DO € NP  RN  Other\_\_\_\_\_ Professional License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Highest degree held: € Master’s € DNP € PhD € MD € DOState 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Preceptor’s Signature: Date:** |

NP Program CoordinatorDr. Wisdom Chambers email kwisdom1@health.fau.edu Cell 561 543 9445 |