WAGNER COLLEGE
EVELYN L. SPIRO SCHOOL OF NURSING

Master of Science in Nursing, Family Nurse Practitioner
Preceptor Request Form

Student must fill out form completely for each Preceptor or it will be returned. Please print.

Date: _____ Semester: Fall | Spring | Summer | Course # NR641 / NR643 / NR645

Last Name: _____ First Name: _____ Cell Phone: _____

Clinical Practicum Site and Affiliation Agreement Initiation Information.

(Your place of employment cannot be your preceptor site, unless otherwise approved)

Practice Setting (circle one) Private Practice | Clinic | Hospital | Long Term Care

Site Name (Full name not initials): _____

Site Address: _____

City: _____ State: _____ Zip Code: _____

Name of Parent Agency (if site is managed by a parent company): _____

If this is a new site or Parent Agency, the following information is required:

Person who is responsible for contract management at this site:

Last name: _____ First Name: _____ Position/Title: _____

Email: _____ Phone: _____ Fax: _____

Preceptor Information (A copy of the Preceptor's Resume/CV is required if not on file in Nursing Office).

Last name: _____ First Name: _____ Position/Title: _____

Email: _____ Phone: _____ Fax: _____

Education (Please check all that apply:

MSN ____ DNP ____ PhD ____ MD ____ DO ____ MASTERS (OTHER) ____ DOCTORATE (OTHER) ____

Years of experience as a practitioner: _____

What days of the week are you available (circle all that apply) **S M T W T F S**

Licensure (Verification of Preceptor's License is required. Print verification and submit along with this request).

(NYS – http://www.op.nysed.gov/opsearches.htm / https://newjersey.mylicense.com/verification click person search).

RN License No. _____ Expiration Date: _____

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

MD/DO: License No. _____ Expiration Date: _____ Specialty: _____

Certification Type: _____ Certifying Body: _____

Clinical Site Information

To the right is a list of types of patients that may be at your site. please check any and all that apply to this clinical site.				To the left, please estimate the percent of time the preceptor spends with each type of patient this clinical site.
		Adult		
		Family Practice		
		OB/GYN		
		Pediatrics		
		Urgent Care		

Preceptor Signature_____ **Date**_____