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

<table>
<tr><td rowspan="6">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.</td><td></td><td>Adult</td><td></td><td rowspan="6">To the left, please estimate the percent of time the preceptor spends with each type of patient this clinical site.</td></tr>
<tr><td></td><td>Family Practice</td><td></td></tr>
<tr><td></td><td>OB/GYN</td><td></td></tr>
<tr><td></td><td>Pediatrics</td><td></td></tr>
<tr><td></td><td>Urgent Care</td><td></td></tr>
<tr><td colspan="3"></td></tr>
</table>

Preceptor Signature (optional)____________________ **Date**____________