Western University of Health Sciences

College of Graduate Nursing

Master of Science in Nursing, Family Nurse Practitioner Program

PRECEPTOR AND CLINICAL SITE INFORMATION FORM

STUDENT NAME: ____

Is student employed at facility/clinic? ❑Yes ❑No

PRECEPTOR NAME: ____
(Last) (First) (Middle) (Title)

Name of Responsible Party/Medical Director/Owner: ______________________________

Current Facility/Clinic Name: ____

Street Address: ____

City: ______________________________State: __________ Zip: __________

Day Telephone: __________ Fax: __________ E-mail: ______________________

Each semester a clinical faculty may contact you about your current MSN/FNP student.

Best e-mail address for electronic evaluations of student, which are required at the end of each semester and/or at the end of the student's rotation: ______________________

❑ **Please check if additional documentation such as an affiliation agreement is necessary for the student to complete clinical hours with you or at your facility. If checked please provide the name, phone number and/or e-mail (if different from above) for the contact person.**

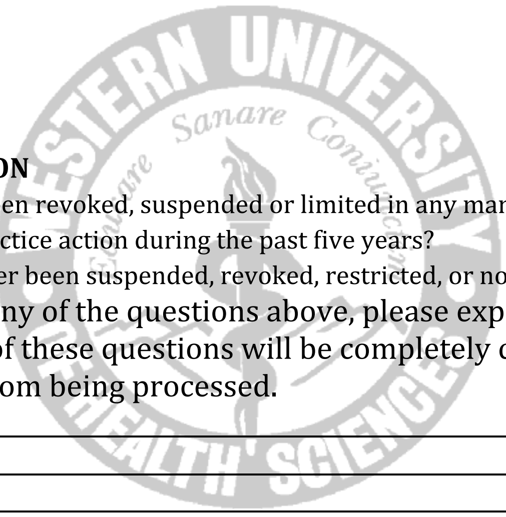
Name	**Phone Number**	**E-mail**

PRACTICE INFORMATION

Practice Specialty:

❑Family Practice
❑OB/GYN
❑Adult Practice
❑Internal Medicine
❑Pediatrics
❑College Health
❑Urgent Care/ER
❑Other: ________________
❑Board Certified in your specialty

Physician/NP/CNM: State Lic. #: ________ State Cert/Recertification Date: __________



BACKGROUND INFORMATION

Has your medical license ever been revoked, suspended or limited in any manner? ❑**Yes ❑No

Have you been party to a malpractice action during the past five years? ❑**Yes ❑No

Have your hospital privileges ever been suspended, revoked, restricted, or not awarded? ❑**Yes ❑No

** If you answered YES to any of the questions above, please explain. *Kindly note*, an affirmative answer to any of these questions will be completely confidential and will not preclude this application from being processed.

____

____

____

____

Please attach a copy of your Curriculum Vitae.

My signature below authorizes Western University of Health Sciences or their representatives to contact individuals, organizations, agencies, and hospitals which I have named in this document. I agree to release Western University of Health Sciences from civil liability regarding the processing of my application. Finally, I hereby release from liability any and all individuals and organizations that provide information to Western University of Health Sciences in good faith without malice concerning my professional competence, ethics, character and other qualifications to be a clinical instructor and I hereby consent to the release of such information.

______________________________ ______________________________

Clinical Experience Start Date **Clinical Experience End Date**

____ ____________________

Preceptor Signature **Date**

__________________________________ ____

Student Name **Student Signature**

We appreciate your willingness and enthusiasm to assist with the clinical training of our students. We are available by phone, e-mail, and fax for any immediate concerns or questions.

Western University of Health Sciences
College of Graduate Nursing
Attn: MSN/FNP Department
309 E Second Street
Pomona, CA 91766
Tel: (909) 469-5523
Fax: (909) 469-5521
jlcastro@westernu.edu

For College Use Only
Date Received: _______________
Date Approved: _______________
Approval Expiration: ☐Yes ☐No
Date: ____________