



COURSE INFORMATION: Course Number: NURS _____ Semester: _____
Course Faculty: _____

(NP students only; check one) Rotation= *Primary Care/internal medicine*
 Geriatrics
 Adolescent
 Urgent care
 Gynecology

STUDENT INFORMATION:

Name _____
Address _____ City _____
State _____ Zip _____
Home Phone _____ Mobile _____
E-Mail _____
DAY of week at site _____
Number of years in role: _____ Number Students supervised concurrently: _____

PROPOSED PRECEPTOR INFORMATION:

Name/Title: _____
Work Address: _____
City _____ State _____ Zip _____
Phone _____ Fax _____
E-Mail: _____

Mailing Address if different from above:

Address: _____
City _____ State _____ Zip _____
Phone _____ Fax _____

OFFICE MANAGER

Provide the following information regarding the person authorized to enter into an agreement for this site.

Office Manager Name: _____
Work Address: _____
City _____ State _____ Zip _____
Phone _____ Fax _____
E-Mail: _____

Secure a Business Card from the preceptor

*(In this spot)
that includes:*

*Name, Title, Employment Site Address
Telephone #, Fax, E-mail address.
Corporate Identification*