



Graduate Preceptor Agreement Form

Student Name: _____

EID: _____ What unit will you be working on: _____

Day(s) of week at site: _____ Anticipated duration of clinical experience: _____

Preceptor or Office Manager to fill out only:

I, _____ (*preceptor name*) agree to precept

_____ (*student name*).

Preceptor signature: _____

- Michigan RN & CNS/NP License Number: _____
Expiration Date (s): _____
- Certification Specialty: _____ Certifying Body (ANCC or AANP): _____
- Michigan MD or DO License Number: _____ Expiration Date: _____
- Specialty Board Certification: _____
- Number of students precepted concurrently with this applicant: _____
- Years in role: _____
- The following items are required to be on file for accreditation purposes:
 - CV / Resume
 - Copy of highest degree
 - Copy of Medical / RN License
 - Board Certification (MD, DO, NP, CNS, or PA)
- Please submit these documents to Dr. Vicki L. Washington: vwashing@emich.edu

To be filled out by EMU only:

- Is an affiliation agreement in place: ____ Yes ____ Pending
- Approved _____ Denied _____
- By: _____ Date: _____

Students: Please submit both preceptor forms to Project Concert and by email to Vicki L. Washington. If you have any questions, please contact Vicki L. Washington: vwashing@emich.edu