



Appendix H

Preceptor Information and Acknowledgement Form (Preceptor Form)

Student Name: _____ Student ID: _____

PRECEPTOR INFORMATION

Name: _____	Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No
Credentials: _____	Board Cert. Organization: _____
Email: _____	Board Cert. Number: _____
Phone: _____	License #: _____
Years of Practice: _____	Clinical Site Name: _____
Foreign Languages: _____	Clinical Site Address: _____

PRECEPTOR CURRENT PRACTICE AREA (check all that apply)

- Family/Primary Care (includes lifespan)
 Women's Health, Obstetrics, Gynecology
 Geriatrics
 Pediatrics
 Emergency
 Urgent Care
 Psych/Mental Health
 Pain Management
 Adult/Internal Medicine/General
 Other/Specialty: _____

PRECEPTOR RESPONSIBILITIES

By signing this form, the above named preceptor agrees to the following:

- I have read the Family Nurse Practitioner Clinical Handbook and agree to abide by its guidelines (see QR code).
- I will read the syllabus provided by student or clinical faculty for each clinical course.
- I concur I have access to the preceptor training information checklist (see QR code).
- I understand I will need to confer with the USU clinical faculty during midterm and at the end of the course(s) to provide information. I understand this is necessary for progress in the clinical experience.
- I understand that the University and its accreditors require a clinical site visit to evaluate the student's performance regarding assessment and treatment of patients, and this may take place via televideo conferencing or in-person, per the specific state guidelines for APRN programs.
- I agree to act as Preceptor to the student listed above as part of his/her enrollment at the United States University College of Nursing and Health Sciences program clinical courses.
- I agree to precept no more than 2 NP students per shift from all schools combined. If 2 students are with the preceptor on the same shift, the preceptor is expected to not see patients independently.
- I agree to monitor student hours and be present during all student experiences.
- I agree to complete evaluations of the student and clinical experience, as necessary.

For standard credentialing, please attach the following to this form:

- Current CV/Resume
 Professional License
 Board Certification certificate



Preceptor Signature: _____ DATE: _____