CLINICAL SITE / PRECEPTOR REQUEST FORM INFORMATION

SIUE School of Nursing Graduate Student:

This form is for requesting a clinical site and preceptor to meet course/practicum requirements. A new form will need to be completed for each course, clinical site, and preceptor.

Please note that you are responsible for:

1. Selecting a clinical site and preceptor.
   (A list of contracted agencies can be found on the school of nursing webpage, graduate blackboard site, or by contacting the Director of Clinical Acquisitions.)
2. Completing the “Clinical Site & Clinical Preceptor Request Forms” and obtain a copy of your preceptors current license and, if applicable, copy of their respective certification. (Certification is needed for NP's only.)
3. Submit the completed packet of information to the Director of Clinical Acquisitions.
   (Completed packet includes your portion, as well as the information from the proposed preceptor. The aforementioned should be scanned and sent via email. Incomplete forms may be returned to you.)
   Receipt of a completed packet will initiate the process for verifying contract placement and/or initiating a new agreement.

Initiating a new contract/ field practice agreement takes 3-6 months to expedite.

Questions? Email the Director of Clinical Acquisitions at shcompt@siue.edu or call 618-650-3341.
Clinical Site & Clinical Preceptor Request Form

TO BE COMPLETED BY STUDENT

Student Information

Name: ________________________________________________________________

Home Telephone: ____________________           Work Telephone: ____________________

Cell Telephone: _____________________    SIUE E-Mail: __________________________

Student’s Current Employer & Work Area: ______________________________________

Please provide the following information for the course, semester, and year for which this
request is being submitted:

Please circle:  Fall  Spring  Summer

Year: _______

Course Number for which this request is being placed:
NP: 513___  571___  572___  573___  576___  577___
NE: 582___  586___  585___
HCNA: 590___  591___  592___  594___
CRNA: 513 ___

Clinical Site Information

Facility Name: ______________________________________________________________

Address: ___________________________________________________________________

City, State, Zip Code: ___________________________________________________________________

Main Phone Number: _________________________________________________________

Do we have a current field practice/agreement (aka: contract) with this agency? If not, to whom should a
contract be sent? (Please provide name of the ‘contract authority’ for the facility, this is often the CEO/ COO/ CFO, Dir of Educ, or
Dir of Nursing. This is the person responsible for signing contracts for the facility.)

Name of Prospective Preceptor and Credentials:
____________________________________________________________________________

Prospective Preceptor’s contact/telephone number: ____________________________

Prospective Preceptor’s email address: ________________________________
Student Name: ______________________________________________

PRECEPTOR INFORMATION
(TO BE COMPLETED BY PRECEPTOR)

Preceptor Name & Credentials: ________________________________ Date:________________

Position/Title: ______________________________________________________________________________________

Home Phone: ___________________ Cell/Beep No.: ____________________

Current Facility – Primary Practice Location (Name): _____________________________________________

Work Address: ______________________________________________________________________________________

Work Phone: ___________________ E-Mail: ___________________________

Setting: (i.e.: primary care/ambulatory, fast track/ER, etc.) Please specify: __________________________

Parent Corporation Affiliation: Yes _____ No _____
If ‘Yes’, List name and address: ______________________________________________________________

Educational & Licensure Information:

Nurse: Please provide a copy of your current license AND current certification

MSN: Year received: ___________________ Rcvd from (list institution):

_________________________________ __________________________________________________________________

APRN Certifying Board: __________________________________

Physician: Please provide a copy of your current license.

MD: Year received: ___________________ Received from (list institution):

MD/DO License No: ___________/

State: ( ) Illinois ( ) Missouri

Exp. Date: ___________________

Certifying Board: _______________________________________

If APRN:
No. of years in APRN role:
Certification (circle): FNP / Acute CareNP/ Adult NP / PNP / WHNP / GNP Other: __________________
Area(s) of Practice (circle): Family / Adult / Pediatric / Women’s Health / Geriatric Other: __________
Number of students supervised concurrently: ( ) None ( ) One Other:____________

As a preceptor, I am willing to provide access to any documents necessary to verify the
above information. (i.e.: reaccreditation of program by CCNE)

Signature: _____________________________________________