SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

School of Nursing, Alumni Hall, PO Box 1066
Edwardsville, IL 62026- (Tel: 618-650-3341)

PRACTICUM SITE / PRECEPTOR REQUEST PACKET

Purpose: This packet is for requesting a clinical site and preceptor to meet course/practicum requirements.

A complete packet consists of the following:
Page 1: Student form
Page 2: Preceptor form
Page 3 -4: Preceptor license and certification (if applicable)

A complete packet needs 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.)
2. Coordinate completion of the "Practicum Site / Preceptor Request Packet".
3. Upload the completed packet to the School of Nursing Master's Program Blackboard site (or DNP Program Information site for doctoral students) under the correct semester and course icons.
   (Completed packet includes: the student page, preceptor page, a copy of the preceptor professional nursing or medical license, as well as the specialty certification (for APNs only), if applicable. You may look up a provider's license at www.nursys.com and take a screenshot to upload. The aforementioned should be scanned into one document and uploaded. Receipt of the completed packet will initiate the process for verifying contract placement and/or initiating a new agreement.
4. If you have any questions about contracted sites or status of paperwork, please contact Dr. Kathy Ketchum at kketchu@siue.edu or 618-650-3936.
5. If the site where you want to complete your practicum is NOT on the contract list on the Blackboard site, you can send an email to Dr. Kathy Ketchum, kketchu@siue.edu, or to the Graduate Secretary.

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

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Practicum Site / Preceptor Request Packet

Page 1: To be completed by the SIUE graduate 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___677___
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: ____

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Student Name: ______________________________________

PRECEPTOR INFORMATION
(TO BE COMPLETED BY PRECEPTOR)

Preceptor Name & Credentials: ______________________________ Date:________________

Position/Title: ____

Home Phone: ________________________ Cell/Beeper 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 Practitioners: *Please provide a copy of your current license AND current certification*

Nurse Educators & Administrators: *Please provide a copy of your current license.*

Physicians: *Please provide a copy of your current license.*

Detailed Nurse Preceptor Information

MSN: Year/Institution: ___________________________
____

PhD/DNP: Year/Institution:_______________________

APRN License No.: _____________________________
State: ( ) Illinois ( ) Missouri
Exp Date: ________________________________

Certifying Board: ____________________
Certification (circle): FNP / ANP / PNP / WHNP / GNP/or other: ___________________________________

Detailed Physician Preceptor Information

MD: Year received: __________

Received from (list institution):
____

MD/DO License No:
___________/______________
State: ( ) Illinois ( ) Missouri
Exp. Date: __________________

Certifying Board:
____

Both Nurses and Physicians:
No. of years in current role: ___________ Practice Areas: ____
Number of students supervised concurrently this semester: _________.

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: ______________________________________