SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
School of Nursing, Alumni Hall, PO Box 1066
Edwardsville, IL 62026-1066

INSTRUCTIONS FOR COMPLETING CLINICAL SITE / PRECEPTOR REQUEST FORM

SIUE School of Nursing Graduate Student:

This form is for requesting a clinical site and preceptor to meet course requirements. A new form will need to be completed for each course, clinical site, and preceptor. *Please be aware that initiating a new contract agreement takes 3-6 months to expedite.*

Please note that you are responsible for:

- Selecting a clinical site and preceptor.
- Completing and submitting the "Clinical Site & Clinical Preceptor Request Form". (Incomplete forms may be returned to you…creating a delay in processing.)
- Deliver completed forms to the Director of Clinical Acquisitions.
  (Director of Clinical Acquisitions office is Rm 2119 OR Fax: 618-650-5037)
- Obtaining approval from your current faculty regarding your site and preceptor selection.

Due to regulatory requirements for program accreditation, your preceptor will be asked to provide a copy current licensure and certification,

Questions? Email shcompt@siue.edu or call 618-650-3341

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Clinical Site & Clinical Preceptor Request Form

TO BE COMPLETED BY STUDENT

Student Information

Name: _____

Address: _____

City, State, Zip Code:
_____

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:

Your specialization: NP___ NE___ HCNA ____ CRNA ____ Please circle: Fall Spring Summer Year: _____

Course Number for which this request is being placed:

NP: 513___ 571___ 572___ 573___ 576___ 577___

NE: 585b___ HCNA: 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: _____

Have you received approval from your current faculty regarding your preceptor & site selection? If yes, please list the name of the faculty from whom you received approval: _____

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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

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

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

Certifying Board: _____

Physicians:
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: _____

No. of years in APRN role: _____
Certification (circle): FNP / ANP / 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: _____