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, or by contacting the Director of Clinical Acquisitions.)
2. Coordinate completion of the "Practicum Site / Preceptor Request Packet".
3. Submit the completed packet to the Director of Clinical Acquisitions.
   (Completed packet includes: the student page, preceptor page, preceptor license and preceptor certification, if applicable. The aforementioned should be scanned and sent via email to the Director of Clinical Acquisitions at shcompt@siue.edu. Incomplete forms may be returned to you.) Receipt of the 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.

Submit the complete packet via email to:
Sheri Compton-McBride, MSN, RN
Director of Clinical Acquisitions & Instructor, School of Nursing
Southern Illinois University Edwardsville
Alumni Hall; Office 2119
Campus Box 1066
Edwardsville, IL 62026
Tel: 618-650-3341
Fax: 618-650-5037
shcompt@siue.edu

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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___
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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SIUE Student Name: ______________________________

Page 2: To be completed by the preceptor
Preceptor Information
Page 3-4: Copy of current license and APRN certification (if applicable)

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:
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: ______________________________