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

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.

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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: _____

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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:
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: _____