

**This completed form must be submitted 6 weeks prior to clinical rotation start date. The preceptor and site must be approved by USI prior to the start of clinical rotation.**

## PART ONE: STUDENT INFORMATION

Student Name: \_\_\_\_\_ Student ID: \_\_\_\_\_ Student USI Email Address: \_\_\_\_\_  
Current City, State: \_\_\_\_\_ Student Nursing License #, State: \_\_\_\_\_  
USI Course#(s)/Term(s)/Year(s): \_\_\_\_\_

## PART TWO: PRECEPTOR INFORMATION

Preceptor Name: \_\_\_\_\_  
Preceptor Email Address: \_\_\_\_\_ Preceptor Title: \_\_\_\_\_  
Preceptor Specialty(ies): \_\_\_\_\_ Professional License Number: \_\_\_\_\_ State Issued: \_\_\_\_\_  
Original Date Issued (MO/YR): \_\_\_\_\_ Expiration Date: \_\_\_\_\_ DEA: \_\_\_\_\_  
Board Certified: \_\_\_\_\_ Certifying Board: \_\_\_\_\_ Certification ID #: \_\_\_\_\_  
Preceptor Years at Current Practice: \_\_\_\_\_

## PART THREE: SITE INFORMATION

Name of Site: \_\_\_\_\_  
This site is part of (if owned by larger corporation): \_\_\_\_\_  
*If this site is part of a larger entity, please note the name of the entity on the line above.*

Site Address: \_\_\_\_\_ County: \_\_\_\_\_ City, State and Zip: \_\_\_\_\_  
Main Office Phone: \_\_\_\_\_ Office Manager Name: \_\_\_\_\_ Office Manager Phone: \_\_\_\_\_  
Fax Number: \_\_\_\_\_ This site is a telemedicine site: \_\_\_\_\_

*If the site has multiple offices, please note the other addresses of where the student will be below. You may also attach additional pages noting this information.*

Site Name (Location 2): \_\_\_\_\_ Site Address: \_\_\_\_\_ County: \_\_\_\_\_  
City, State and Zip: \_\_\_\_\_ Main Office Phone: \_\_\_\_\_ This site is a telemedicine site: \_\_\_\_\_

Site Name (Location 3): \_\_\_\_\_ Site Address: \_\_\_\_\_ County: \_\_\_\_\_  
City, State and Zip: \_\_\_\_\_ Main Office Phone: \_\_\_\_\_ This site is a telemedicine site: \_\_\_\_\_

## PART FOUR: PRECEPTOR / SITE SURVEY – Completed by preceptor or office manager.

Have you previously served as a clinical preceptor/teacher? \_\_\_\_\_

*If yes, please indicate all student categories that apply:*

Clinical Nurse Specialist      Nurse Practitioners      Physician Assistants      Medical Students      Other \_\_\_\_\_

Do you anticipate serving as a clinical preceptor for more than one student at a time? \_\_\_\_\_

Indicate the number of hours you will be able to precept each day:

Monday\_\_\_\_ Tuesday\_\_\_\_ Wednesday\_\_\_\_ Thursday\_\_\_\_ Friday\_\_\_\_ Saturday\_\_\_\_ Sunday\_\_\_\_

What is the average number of patients seen by you in a \_\_\_\_ hour period? \_\_\_\_\_

How many practitioners are in your practice? \_\_\_\_\_

What are their specialties? \_\_\_\_\_

How many exam rooms/beds are available per practitioner at any one time? \_\_\_\_\_

List any special procedure rooms and their use: \_\_\_\_\_

Indicate types of minor surgeries and procedures that are done in your practice: \_\_\_\_\_

Does your practice involve caring for patients in acute care facilities? \_\_\_\_\_  
If yes, please indicate the frequency: \_\_\_\_\_

Are there any on-call opportunities? \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

Describe the approximate patient mix in the practice by percentages:  
Adults \_\_\_\_\_%      Pediatrics \_\_\_\_\_%      OB \_\_\_\_\_%      Geriatrics \_\_\_\_\_%      Other: \_\_\_\_\_ %

What are the types and number of support staff employed in your practice?  
Number: \_\_\_\_\_      Types: \_\_\_\_\_

Will the graduate nursing student be allowed to record on the patient's record? \_\_\_\_\_  
Will the graduate nursing student be allowed to enter on the E.H.R.? \_\_\_\_\_  
Will the graduate nursing student be allowed to dictate? \_\_\_\_\_

### PART FIVE: PRECEPTOR AGREEMENT AND ACKNOWLEDGEMENT

**Preceptor Agreement:** I have reviewed the goals and responsibilities of the graduate nursing student, the preceptor, and faculty. I will provide the student with clinical experiences that facilitate the learning goals of the student as agreed upon by the student, the faculty advisor, and me. I will facilitate and review the student's learning activities and will submit the required evaluation to the Graduate Nursing Program. I understand that there will be no remuneration for this service. I agree to serve as a preceptor for the Graduate Nursing Program at the University of Southern Indiana. This agreement is valid for the course/semester/year listed in Part One of this agreement.

**Acknowledgement of Receipt and Understanding of Preceptor Orientation Packet:** I acknowledge that I have received and reviewed the USI Graduate Nursing Program Preceptor Orientation Packet and understand the roles, responsibilities, expectations, and policies related to serving as a preceptor for the University of Southern Indiana Graduate Nursing Program. I agree to comply with the guidelines outlined in the orientation materials and understand that course faculty are available for consultation and support throughout the clinical experience.

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined above, including the Preceptor Agreement and Acknowledgement of Receipt and Understanding of the Preceptor Orientation Packet.

**Preceptor Signature:** \_\_\_\_\_      **Date:** \_\_\_\_\_

#### Title IX Information for Preceptors:

USI does not tolerate acts of sexual misconduct, including sexual harassment and all forms of sexual violence. It is important to know that federal regulations and University policy require faculty to promptly report incidences of potential sexual misconduct known to them to the Title IX Coordinator to ensure that appropriate measures are taken and resources are made available. The University will work with you to protect your privacy by sharing information with only those who need to know to ensure we can respond and assist. Find more information about sexual violence, including campus and community resources, at [www.usi.edu/stopsexualassault](http://www.usi.edu/stopsexualassault)

**The student should submit completed forms to: [USI1Nursing@usi.edu](mailto:USI1Nursing@usi.edu)**

Kinney College of Nursing and Health Professions, University of Southern Indiana

**Subject Line: [Student First and Last Name] Preceptor Packet**

*To avoid processing delays, please type responses to each field and send as a PDF attachment.*

<b>For Office Use Only</b>				
Received by _____	Date _____	License Verified (S) _____	License Verified (P) _____	MUA _____
CEA _____	Auto-renewed? _____	Expiration Date _____		
Approved as Preceptor _____	Approval Date _____	Faculty Signature _____	Additional Comments _____	
Green Light Email Sent _____	Typhon (P) _____	Typhon (Site) _____	Uploaded into Typhon (Date) _____	by _____