UNIVERSITY OF SOUTHERN INDIANA
Kinney College of Nursing and Health Professions

USI Graduate Nursing Preceptor Packet

This completed form must be submitted 6 weeks prior to the clinical rotation's 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: _____ 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:_____ City, State, and Zip: _____ County:_____

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:_____ Telemed Site: _____

Site Name (Location 3): _____ Site Address:_____ County:_____

City, State, and Zip: _____ Main Office Phone:_____ Telemed 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

The student should submit completed forms to: 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.

For Office Use Only

Received by_____ Date_____ License Verified (S) ☐ License Verified (P) ☐

CEA _____ Auto-renewed? ☐ Expiration Date_____

Approved as Preceptor ☐ Approval Date_____ Faculty Signature_____ Elective Rotation? ☐

Additional Comments_____ Green Light Email Sent ☐ Typhon (P) ☐ Typhon (Site) ☐

Form G Updated 07/2026