Preceptor Approval Request Form – RN-BSN Program

This form just be completed and signed by the student and the preceptor and returned to the RN-BSN Program Coordinator at Chipola College to obtain clearance to begin the clinical experience.

Deadline for Submission: End of the 3rd week of the semester

All information requested must be provided and complete before submission. Fax your completed forms to FAX # 850-718-2495

I. Student Information (Please print or type the following):

Student Name: __________________________________________
Instructor Name: _________________________________________
Semester/Year: __________________________________________

I understand that I may not begin clinical hours with this preceptor until I have received clearance from the RN-BSN Program Coordinator. I understand that it is my responsibility to make sure that all required forms are on file and that I am cleared to begin my clinical experience. I also understand that if the facility where I intend to complete my clinical experience does not have an approved contract or affiliation agreement with Chipola College, then the RN-BSN Program Coordinator must be notified to initiate this process.

________________________________________________________________________
Student Signature ___________________________ Date ________________

II. Preceptor Information: (Please print or type the following):

Preceptor Full Name: __________________________________________
Include all credentials that apply (ARNP, BSN, DSN, MSN, RN, etc.)

Present Job/Title: ___________________________ Length of Time in Current Role: _____________

Health Care Provider License # & State of Issue: ___________________________

Preceptor Phone Number: ______________________ Email Address: _______________________

Facility Name: ____________________________________________________________________
(Full Street Address, including suite/room numbers)

________________________________________________________________________
City __________________ State ____________ Zip Code __________

Preceptor Educational Background (please list all degrees conferred – add additional sheets, if necessary)

<table>
<thead>
<tr>
<th>College or University Attended</th>
<th>Degree Earned (Bach, Master’s, PhD)</th>
<th>Major Area of Study</th>
<th>Month/Year Degree Conferred</th>
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I certify that the information provided above is accurate and truthful to the best of my knowledge. I agree to precept the student identified above according to the guidelines provided to me in the course syllabus and confirmed by the course instructor and the RN-BSN Program Director.

________________________________________________________________________
Preceptor Signature ___________________________ Date ________________