

Preceptor Agreement

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.

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 one year with the option to renew for a second year, unless written notification is received from either the student or the USI Graduate Nursing Program.

PART ONE: Student Name: _____ Student ID: _____

Student Email Address: _____ Student Current City, State: _____

Student Nursing License #, State _____ USI Course#/Term Taken: _____

PART TWO: Preceptor Name: _____

Preceptor Specialty (ies) _____

Preceptor Email Address: _____

Preceptor Title: _____ Professional License Number: _____

State Issued: _____ Year Issued: _____ Expiration Date: _____ DEA: Yes ___ No ___

Board Certified: Yes ___ No ___ Certifying Board: _____ Certification ID # _____

PART THREE: Name of Site: _____

This Site is Part of (if owned by larger corporation): _____

If the site has multiple offices, please note the addresses of where the student will be. You may attach additional pages noting this information. If this site is part of a larger entity, please note name of the entity on line above.

Site Address: _____ County: _____

City, State and Zip: _____

Main Office Phone: _____ This site is a telemedicine site (please circle one) No Yes

PART FOUR: 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

Submit completed forms to:
 College of Nursing and Health Professions
 University of Southern Indiana
 Attn: Sr. Administrative Assistant–CNHP
 Email: USI1Nursing@usi.edu

For Office Use Only:

Received by _____ Date _____

License Verified _____ MUA _____ MOU _____

Approved as Preceptor: Yes ___ No ___

 Faculty Signature

Approval

Date _____ Green Light _____