New Agency _____ Continuing Agency _____

Family Nurse Practitioner Clinical Planning Form

CSU School of Nursing

Students are responsible for completion of these forms. You will need a form for each semester of your program where clinicals are required. *PLEASE NOTE: YOUR PRECEPTOR SHOULD ONLY BE ASKED TO REVIEW, SIGN, AND PROVIDE YOU WITH THEIR CV or RESUME.* Scan and Email your completed forms to pace_msnfnp@columbusstate.edu ***Only completed forms will be accepted***. *You will not be able to register for courses until completed forms are received.*

PART A – STUDENT & PRECEPTOR INFORMATION

Student Name ____

Phone Contact Information (with area codes): ________________________________

CSU Email Address____

COURSE INFORMATION

Course Number: _________ Number of Clinical Hours: _________
Course Number: _________ Number of Clinical Hours: _________
Term & Year: __________ (ex. Summer 2015)

PRECEPTOR INFORMATION (Must be completed in full)

Preceptor Name: (printed) ____
(First) (Middle) (Last)

Credentials (circle one): DO MD CRNP CNS CRNM RN Other

Specialty____

License Number __________________________ State ______ Expiration Date _________

Certification Agency ___________________________________ Expiration Date _________

Years in current role ___________ Best phone number to contact ____________________

Email address: ___________________________

I agree to serve as preceptor for ____
(Student)

____ ______________________
Preceptor's Signature Date

If your state requires collaboration and your preceptor is an PCNP or Nurse Midwife, WRITE-IN the name of the **Collaborating Physician** ________________________________
and his/her Certification ________________________________ Expiration Date __________
Certifying Agency ____

Attach current resume/vita of preceptor to this form.

****All information is confidential and only available to school administrator.****

NOTE: At the end of each semester you will receive a letter from CSU with the number of hours you served as a preceptor. If you would like this letter sent to an alternate (home) address instead of the address on form C (agency) please provided that address here

Name:

____

Street Address:

____

City and zip code:

____

Revised and adopted fall 2011; spring 2014; spring 2015.

____ ____________________
FNP Student Signature Date

For CSU office use only:

____ ____________________
CSU Faculty's Signature Date

PART B – PRECEPTOR'S PRACTICE INFORMATION

STUDENTS ARE RESPONSIBLE FOR COMPLETION OF THIS FORM

Student Name: ____________________________ Phone: ___________________________

Clinic/Agency/Hospital Preceptor's Information

Clinic/Agency/Hospital Name: ____

Preceptor's Name: ____

Clinic/Agency/Hospital Street Address: ____

Mailing Address (if different from street address):

____ County ________________________

Telephone with area code ______________________ Fax Number ____________________

Office Manager: ______________________ Email Address __________________________

The *Legal Name* of the clinic, group or physician who owns the practice:

____

(Note: Legal name and clinic name may or may not be the same.)

Projected Effective Date of Contract: ____
(First date possible that student will be in this clinical setting.)

Circle Correct Descriptor of Agency:
Rural Clinic Academic Medical Center Clinic Inner City Clinic
Public Health Department Clinic Specialty Clinic Private Practice
Other _______________________________

Person Legally Authorized to Sign Contracts

Name ____

Complete Mailing Address ____
Street or P.O. Box

____
City State Zip Code County

Telephone Number with area code ____

Fax Number with area code ____________________Email______________________________

Updated 03/02/17 EF