UMMC School of Nursing

2500 North State Street
Jackson, MS 39216-4505
(601) 984-6255 ● (601) 984-6211

PRECEPTOR AGREEMENT

STUDENT NAME: _____

PRECEPTOR/FACILITATOR NAME: _____

CREDENTIALS: _____

LICENSE NUMBER: _____ EXPIRATION DATE:_____

AGENCY NAME: _____

AGENCY ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE:_____FAX:_____EMAIL:_____

Please list all degrees and certifications held. Also list any certifications or other advanced preparation in the field.

Degree/Certification	Year Awarded	Main Field of Study	Educational Institution/Organization

Current Position (unit/dept./floor) -- Work Experience (last 5 years) and/or Area of Expertise

_____

_____

_____

Do you have malpractice insurance? _____ YES _____NO

I hereby _____ **AGREE** _____ **DISAGREE** to serve as a preceptor for the above referenced student.

_____

Signature Date

It is the student's responsibility to ask the preceptor whether the manager and/or HR Department needs to be contacted prior to starting their clinicals

COURSE NUMBER: _____SEMESTER: _____ACADEMIC YEAR: _____