



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

NEW CLINIC REQUEST FORM

STUDENT NAME: _____

PRECEPTOR/FACILITATOR NAME: _____

DATE: _____

I am requesting a CLINICAL EDUCATION PLACEMENT AGREEMENT be initiated with the agency listed below.

1. AGENCY NAME: _____

2. AGENCY ADDRESS: _____

CITY/STATE/ZIP: _____

AUTHORIZED OFFICIAL IN BUSINESS OFFICE: (The preceptor is not the authorized official)

3. NAME: _____

4. EMAIL ADDRESS: _____

5. PHONE: _____ FAX: _____

S.O.N. APPROVAL: _____

SEMESTER: _____ COURSE NUMBER: _____

Summer (June–August) []

Fall (August–December) []

Spring (January–May) []

ACADEMIC YEAR: _____



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: _____