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**GRADUATE STUDENT PRECEPTOR REQUEST/AGREEMENT**

Dear Clinical Preceptor:

Thank you for agreeing to be a preceptor for Oakland University’s Nurse Practitioner Program. We greatly appreciate your expertise, time, and service to our students, the School of Nursing, and to Oakland University. In our program, we emphasize the role of the nurse practitioner as part of the healthcare team. We encourage your participation in our program and welcome your feedback. Our goal is to collaborate with you so the student has the best experience. Should you have any questions or concerns, please do not hesitate to contact us at npclinical@oakland.edu.

As part of our process, we ask that you complete the 2-page form labeled ***Graduate Student Preceptor Request/Agreement***. A signed copy confirms you have agreed to precept the student. This agreement also requests that you indicate the number of hours you agree to precept. If an Affiliation Agreement is not on file at Oakland University, the Clinical Department will contact your office to coordinate.

At the end of the clinical rotation, you will be receiving a certificate of appreciation and a letter, which verifies the hours you agreed to precept the student. If additional verification is needed for your professional certifying body, please do not hesitate to contact us at npclinical@oakland.edu . In addition, you will receive an evaluation form asking you to evaluate your experience with Oakland University, the School of Nursing, and the Nurse Practitioner Program. Your feedback is crucial in helping us to maintain an outstanding program.

Again, we appreciate your time and service to Oakland University’s Nurse Practitioner Program and we look forward to hearing from you in the future.

Kind regards,

**Carolyn Tieppo, DNP, RN, CPNP-PC**

**Director of Nurse Practitioner Programs**

**Oakland University, School of Nursing**

**2042 Human Health Building**

**Rochester, MI 48309**

**cktieppo@oakland.edu**

**Oakland University School of Nursing**

**GRADUATE STUDENT PRECEPTOR REQUEST / AGREEMENT** **(page #1)**

**COURSE:**

[ ]  **NRS 6637 Advance Nursing Care of Episodic Health Conditions**

[ ]  **NRS 6647 Advance Nursing Care of Chronic Health Conditions**

[ ]  **NRS 6657 Advance Nursing Care of Pediatric Patients**

[ ]  **NRS 6667 Advance Nursing Care of Aging Adults**

[ ]  **NRS 6737 Adult and Gerontology Nurse Practitioner Clinical Concepts in Acute Care I**

[ ]  **NRS 6747 Adult and Gerontology Nurse Practitioner Clinical Concepts in Acute Care II**

[ ]  **NRS 6767 Adult and Gerontology Nurse Practitioner Clinical Concepts in Acute Care III**

**Semester (check one):** [ ] Fall [ ] Winter [ ] Summer YEAR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Track (check one):** [ ] FNP [ ] AGPCNP [ ] AGACNP

**STUDENT INFORMATION:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_ **Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Oakland E-mail:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PROPOSED PRECEPTOR INFORMATION:**

Office Manager: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provide the following information regarding the person authorized to enter into an agreement for this site.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***School of Nursing Clinical Department Use Only Below This Line***

 Preceptor Vetted by Clinical Department: YES [ ]  NO [ ]  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 AA on file YES [ ]  NO [ ]  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Preceptor/Site Data Added to Spreadsheet Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date Lead Faculty Approved Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Original→ Clinical Department

**GRADUATE STUDENT PRECEPTOR REQUEST / AGREEMENT (page # 2)**

**Preceptor’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer (**Corporate**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital Unit (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **E- Mail address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Michigan RN License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

APN Certification (include specialty): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Michigan MD or DO License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty Board Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Graduate Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Graduate Educational Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Undergraduate Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Undergraduate Educational Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please attach your CV/Resume and business card to this form)**

Are you **employed** by a health system? [ ] Yes [ ]  No Name: ­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you **credentialed** by a health system? [ ] Yes [ ]  No Name: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree to act as preceptor for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for **up to** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **hours**.

 Student’s Name \*Up to 210 hours or 280 in NRS 6767

**Preceptor Signature:** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return (email preferred) to the Clinical Department:**

**Oakland University School of Nursing**

**Clinical Department**

**433 Meadow Brook Rd**

**Rochester, MI 48309**

**npclinical@oakland.edu**