****

**NP PRECEPTOR REQUEST & DATA FORM**

Dear Clinical Preceptor:

Thank you for your willingness 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.

As part of our process, we are asking you complete page 2 of the 2-page form. The information is required for our accreditation. This form also asks for you indicate the number of hours you are able to precept. If an Affiliation Agreement is not on file at Oakland University, the Clinical Department will contact you and/or your office to coordinate. ***Please return the form to npclinical@oakland.edu***

At the beginning of the rotation, you will receive detailed information about the course, the student evaluation form, and faculty contact information. At the end of the clinical rotation, as needed, you can request a certificate of service, 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. In addition, at the end of the calendar year, 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 seeing you in the future.

Kind regards,

Carolyn Tieppo, DNP, RN, CPNP-PC

Director, Nurse Practitioner Program

Oakland University, School of Nursing

2042 Human Health Building

Rochester, MI 48309

[cktieppo@oakland.edu](mailto:cktieppo@oakland.edu)

**Oakland University School of Nursing**

**NP PRECEPTOR REQUEST: PRIMARY CARE**

**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**

**Semester (check one):** Fall Winter Summer **Year**: Click or tap here to enter text.

**Track (check one):** Family Nurse Practitioner Adult-Gerontological - Primary Care

**STUDENT INFORMATION:**

**Name: Click or tap here to enter text. Date: Click or tap here to enter text.**

**Address: Click or tap here to enter text.** **City**: Click or tap here to enter text.

**State:Click or tap here to enter text.Zip Code**: Click or tap here to enter text.**Phone:Click or tap here to enter text.**

**Mobile: Click or tap here to enter text.**  **Oakland E-mail:** Click or tap here to enter text.

**PROPOSED PRACTICE INFORMATION: (To be completed by student)**

**Practice Name:** Click or tap here to enter text.

**Office Manager/Contact:** Click or tap here to enter text. **Phone:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**City:** Click or tap here to enter text. **Zip code:** Click or tap here to enter text.

**Office Contact E-mail address**: Click or tap here to enter text.

**Phone**: Click or tap here to enter text. **Fax**: Click or tap here to enter text.

**(Next page for preceptor to complete)**

**PRECEPTOR INFORMATION**

**Preceptor Name**: Click or tap here to enter text.

**Preceptor Email**: Click or tap here to enter text. **Phone**: Click or tap here to enter text.

**Address**: Click or tap here to enter text.

**City**: Click or tap here to enter text. **Zip code**: Click or tap here to enter text.

**# Of hours typically worked per week**: Click or tap here to enter text.**Primary days**: Click or tap here to enter text.

**Graduate Educational Institution**: Click or tap here to enter text.

**Degree Earned**: Click or tap here to enter text. **Date Received**: Click or tap here to enter text.

**Michigan RN License Number**: Click or tap here to enter text. **Expiration Date**: Click or tap here to enter text.

**NP Certification Board: Expiration Date**: Click or tap here to enter text.

**NP Board Credentials**: Click or tap here to enter text. **Date Received**: Click or tap here to enter text.

**Michigan MD/DO License Number**: Click or tap here to enter text. **Expiration Date**: Click or tap here to enter text.

**Specialty Area of Practice**: Click or tap here to enter text.

**Years of Experience**: Click or tap here to enter text.**Years of Experience in Current Role**: Click or tap here to enter text.

Are you **employed** by a health system? Yes  No Name:

Are you **credentialed** by a health system? Yes  No Name:

**I am willing to precept**: Click or tap here to enter text. **for** Click or tap here to enter text. **hours**

**Student’s Name** **(up to 210 hours)**

**Preceptor Signature:** Click or tap here to enter text. **Date**: Click or tap here to enter text.

*Please include your CV/Resume and attach a business card, if available*

***Please return by email to:***

**npclinical@oakland.edu**