



Department of Nursing and Rehabilitation Sciences

LVN-RN HOSPITAL AFFILIATE PROGRAM

Preceptor Agreement

STUDENT NAME _____

SEMESTER & YEAR _____

COURSE RNSG 1160

RNSG 2527

INSTRUCTOR _____

The purpose of this agreement is to permit students in the nursing program at Angelo State University, to participate in a preceptorship within your agency. This form is for the LVN-RN Hospital Affiliate Program.

Conditions of Preceptorship

- I, the preceptor, will include clock hours to be scheduled as follows:
 24 hours for RNSG 1160 176 hours for RNSG 2527.
- The student will be under the supervision of an agency employee acting as preceptor; this preceptor will only have one student per course.
- The student will work with me in accomplishing goals identified by the student and faculty that are in accordance with course objectives.
- I understand that the faculty member will have primary responsibility for the student's clinical learning experience and will serve as liaison between the Department of Nursing and agency.
- I have read, understand and agree with the responsibilities, policies, and nursing education philosophy noted in the Preceptor Handbook, the Student Handbook, and the "Contract of Association."

PRECEPTOR NAME (Please print) _____

LICENSE # _____ STATE _____ EXPIRES _____ EDUCATIONAL DEGREES _____

TITLE _____ AGENCY _____

ADDRESS _____

STREET/BOX

CITY

STATE

ZIP

TELEPHONE # _____ FAX # _____ EMAIL _____

PRECEPTOR COURSE INFORMATION

Please indicate the preceptor course completed

ASU

INDIANA UNIVERSITY – Please attach a copy of the Certificate of Completion

OTHER (With Department Approval)

PRECEPTOR'S SIGNATURE _____ DATE _____

FACULTY MEMBER'S SIGNATURE _____ DATE _____

PLEASE RETURN TO: Nancy Grafa
FAX: (325) 942-2236
MAIL: Department of Nursing and Rehabilitation Sciences
ASU Station #10902
San Angelo, TX 76909-0902

For college use only (date & initial)

Contract with agency/site _____

Copy mailed to preceptor/site _____

Signed & filed _____

Preceptor biography on file _____

Preceptor Biographical Data Sheet

Fax: (325)942-2236

PRECEPTOR NAME _____ DATE _____

CREDENTIALS (e.g. MSN, RN, CNS, MD) _____

PROFESSIONAL LICENSE NUMBER _____ EXPIRATION DATE _____

ISSUING STATE AGENCY _____

CERTIFICATION Yes No BY WHOM _____ EXP _____

SPECIALTY _____ EMAIL _____

INSTITUTIONAL AFFILIATION _____

OFFICE ADDRESS _____

OFFICE CITY _____ STATE _____ ZIP _____

OFFICE PHONE NUMBERS – VOICE _____ FAX _____

PREFERRED METHOD OF CONTACT (Check one)

PHONE # _____

EMAIL ADDRESS _____

PREFERRED TIME OF CONTACT

DAY (Check one): MON TUE WED THURS FRI ANY WEEKDAY

TIME _____

CONTACT PERSON IN YOUR AGENCY _____

CONTACT PERSON'S PHONE NUMBER _____

This material is kept secured at the ASU Nursing Program and remains confidential.

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NAME _____

DATE _____

SCHOLASTIC BACKGROUND

College or University Degree Date

Graduate or Professional School

ORGANIZATIONS AND PROFESSIONAL ASSOCIATIONS

1. _____
2. _____
3. _____

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