NUR 6349 / Semester _____Year _____

Preceptor Profile Form

Angelo State University - Nurse Educator Program

Institution / Facility Information:

Institution / Facility Name: _____

Address _____

City _____ State _____ Zip_____

Preceptor Information: **(Please Attach Current CV)**

Preceptor Name / Title _____/_____

Preceptor's Phone Number _____

Preceptor's Email Address _____

Preferred Method of Contact (check one): ☐ Phone Number / ☐ Email

Professional License Number _____ Expiration Date _____

APRN / Board Certifying Body (if applicable) _____

Professional Liability Insurance (check one): ☐ Yes / ☐ No Expiration Date_____

Note. This material is kept secure and confidential at the Department of Nursing.

PLEASE SCAN and RETURN by EMAIL or FAX: Attn: Graduate Secretary)/ felicia.armstrong@angelo.edu/ 325-942-2236 (fax