**The University of Scranton**  
**Department of Nursing**  
**Adult Health**  
**Graduate Student Preceptor Request Form**

Please fill in all requested information and submit, email, or fax (570-941-7903) to Donna Cochrane-Kalinoski-Room #319 McGurrin Hall - **donna.cochrane-kalinoski@scranton.edu** AT LEAST ONE MONTH BEFORE THE START OF THE SEMESTER. Incomplete forms will be returned. Thank you.

**GRADUATE STUDENT INFORMATION:**

- **DATE:** ________________
- **STUDENT NAME:** ______________________________________________________
- **CELL PHONE NUMBER:** ________________________________________________

**PLANNED SEMESTER OF CLINICAL:**

- **FALL SEMESTER** _____________ **YEAR** ______________
- **SPRING SEMESTER** _____________ **YEAR** _________________

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**PRECEPTOR INFORMATION:** (This section is to be completed by student – do NOT give the form to the preceptor to complete)

- **PRECEPTOR NAME:** __________________________________________________________________________
- **PRECEPTOR CREDENTIALS** (circle one): MD DO CRNP CNM
- **LICENSE #:** __________________________________________________________
- **SPECIALITY** (circle one): FAMILY PEDS INTERNAL MEDICINE OB/GYN OTHER
- **NAME OF OFFICE OR PRACTICE SETTING:** ______________________________________________________
- **ADDRESS:** __________________________________________ **CITY:** _________________________________
- **PHONE:** ________________________________________________________________
- **OFFICE MANAGER OR OTHER CONTACT PERSON:** ________________________________
- **WITH WHOM HAVE YOU MADE CONTACT?** ____________________________________________

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