The University of Scranton
Department of Nursing

Graduate Student Preceptor Request Form

Please fill in all requested information and submit or fax to Donna Cochrane-Kalinoski- Room #319 McGurin Hall (fax) 941-7903. Incomplete forms will be returned. Thank you.

GRADUATE STUDENT INFORMATION: DATE: _____________________

STUDENT NAME: ___________________________________________________________

ADDRESS: ______________________________ CITY: _____________________________

TELEPHONE: _______________________________________________________________

EMAIL: ____________________________________________________________________

PLANNED SEMESTER OF CLINICAL:

FALL SEMESTER ____________ YEAR ______________

SPRING SEMESTER ____________ YEAR ______________

PRECEPTOR INFORMATION: (This section is to be completed by student)

PRECEPTOR NAME AND CREDENTIALS: _______________________________________

LICENSE #: ________________________________

SPECIALITY: ________________________________

NAME OF OFFICE OR PRACTICE SETTING: ________________________________

ADDRESS: ______________________________ CITY: _________________________

PHONE: _______________________________________________________________

OFFICE MANAGER OR OTHER CONTACT PERSON: ___________________________

WITH WHOM HAVE YOU MADE CONTACT? _________________________________

DO NOT WRITE BELOW THIS LINE

FOR OFFICE USE ONLY:

________________________________________________________________________

________________________________________________________________________

10/09