**The College of New Jersey School of Nursing Health, & Exercise Science**

**PRECEPTOR & CLINICAL SITE REQUEST FORM**

**Family and Adult/Gerontological Nurse Practitioner Programs**

Instructions: Form must be completed by student NOT preceptor. Please type information.

**\*\*Complete all areas of form or it will be returned for completion.\*\***

|  |  |
| --- | --- |
| **Date Request Made** (mm/dd/yyyy):  |  |

 **Semester Requesting: (Term/Year);**

**AGENCY INFORMATION**

|  |  |
| --- | --- |
| Facility’s Full and Legal Name:  |  |
| Address:  |  |
| City: |  |
| State: |  |
| Zip Code: |  |
| ADMINISTRATOR INFORMATION(*Note:* This is the person at agency responsible for signing all legal documents) |
| Name: |  |
| Title: |  |
| Email: |  |
| Phone Number: |  |
| Fax Number: |  |
| Health System Affiliate?  | Y \_\_\_\_ N\_\_\_\_  |
| If Yes, name of Health System/Network: |  |
| Private Practice?  | Y \_\_\_\_ N\_\_\_\_  |
| Is this your place of employment? | Y \_\_\_\_ N\_\_\_\_  |

**PRECEPTOR INFORMATION**

|  |  |
| --- | --- |
| Name:  |  |
| Credentials: |  |
| Type of License: |  |
| Specialty: |  |
| Years of Experience: |  |
| Business Address:  |  |
| City: |  |
| State: |  |
| Zip Code: |  |
| Email: |  |
| Phone Number:  |  | Mobile, Work, Other (drop down box) |
| Fax Number: |  |

**STUDENT INFORMATION –Name:**

|  |  |
| --- | --- |
|  Student Cell Phone Number:  |   |
| Home City: |  |
| State: |  |
| Zip Code: |  |
| NP Track: | FNP \_\_\_\_ AGNP \_\_\_\_  |
| Total number of hours requested with this preceptor: |  |