**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: | |  |