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**GRADUATE STUDENT PRECEPTOR REQUEST/AGREEMENT**

Dear Clinical Preceptor:

Thank you for agreeing to be a preceptor for Oakland University’s Nurse Practitioner Program. We greatly appreciate your expertise, time, and service to our students, the School of Nursing, and to Oakland University. In our program, we emphasize the role of the nurse practitioner as part of the healthcare team. We encourage your participation in our program and welcome your feedback. Our goal is to collaborate with you so the student has the best experience. Should you have any questions or concerns, please do not hesitate to contact us at npclinical@oakland.edu.

As part of our process, we ask that you complete the 2-page form labeled ***Graduate Student Preceptor Request/Agreement***. A signed copy confirms you have agreed to precept the student. This agreement also requests that you indicate the number of hours you agree to precept. If an Affiliation Agreement is not on file at Oakland University, the Clinical Department will contact your office to coordinate.

At the end of the clinical rotation, you will be receiving a certificate of appreciation and a letter, which verifies the hours you agreed to precept the student. If additional verification is needed for your professional certifying body, please do not hesitate to contact us at npclinical@oakland.edu . In addition, you will receive an evaluation form asking you to evaluate your experience with Oakland University, the School of Nursing, and the Nurse Practitioner Program. Your feedback is crucial in helping us to maintain an outstanding program.

Again, we appreciate your time and service to Oakland University’s Nurse Practitioner Program and we look forward to hearing from you in the future.

Kind regards,

**Carolyn Tieppo, DNP, RN, CPNP-PC**

**Director of Nurse Practitioner Programs**

**Oakland University, School of Nursing**

**2042 Human Health Building**

**Rochester, MI 48309**

**cktieppo@oakland.edu**

**Oakland University School of Nursing**

**GRADUATE STUDENT PRECEPTOR REQUEST / AGREMENT** **(page #1)**

**COURSE:**

[ ]  **NRS 6637 Advance Nursing Care of Episodic Health Conditions**

[ ]  **NRS 6647 Advance Nursing Care of Chronic Health Conditions**

[ ]  **NRS 6657 Advance Nursing Care of Pediatric Patients**

[ ]  **NRS 6667 Advance Nursing Care of Aging Adults**

[ ]  **NRS 6737 Adult and Gerontology Nurse Practitioner Clinical Concepts in Acute Care I**

[ ]  **NRS 6747 Adult and Gerontology Nurse Practitioner Clinical Concepts in Acute Care II**

[ ]  **NRS 6767 Adult and Gerontology Nurse Practitioner Clinical Concepts in Acute Care III**

**Semester (check one):** [ ] Fall [ ] Winter [ ] Summer YEAR: Click or tap here to enter text.

**Track (check one):** [ ] FNP [ ] AGPCNP [ ] AGACNP

**STUDENT INFORMATION:**

**Name**: Click or tap here to enter text. **Address:** Click or tap here to enter text. **City:** Click or tap here to enter text.

**State:** Click or tap here to enter text.**Zip:** Click or tap here to enter text.**Home Phone:** Click or tap here to enter text.

**Mobile:** Click or tap here to enter text. **Oakland E-mail:** Click or tap here to enter text.

**PROPOSED PRECEPTOR INFORMATION:**

Office Manager: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provide the following information regarding the person authorized to enter into an agreement for this site.**

Name:Click or tap here to enter text. Title: Click or tap here to enter text.

Address: Click or tap here to enter text. City: Click or tap here to enter text.

E-mail address: Click or tap here to enter text.

Phone:Click or tap here to enter text. Fax:Click or tap here to enter text..

***School of Nursing Clinical Department Use Only Below This Line***

 Preceptor Vetted by Clinical Department: YES [ ]  NO [ ]  Date: Click or tap here to enter text.

 AA on file YES [ ]  NO [ ]  Date: Click or tap here to enter text.

 Preceptor/Site Data Added to Spreadsheet Date: Click or tap here to enter text.

 Date Lead Faculty Approved Date: Click or tap here to enter text.

 Original→ Clinical Department

**GRADUATE STUDENT PRECEPTOR REQUEST / AGREEMENT (page # 2)**

**Preceptor’s Name:** Click or tap here to enter text. **Phone:** Click or tap here to enter text.

Employer (**Corporate**): Click or tap here to enter text. Site Name: Click or tap here to enter text.

Employer’s Address: Click or tap here to enter text. Hospital Unit (if applicable): Click or tap here to enter text.

City: Click or tap here to enter text. Zip Code: Click or tap here to enter text.

Work Phone: Click or tap here to enter text. Work Fax: Click or tap here to enter text.

Other: Click or tap here to enter text. **E- Mail address**: Click or tap here to enter text.

Michigan RN License Number: Click or tap here to enter text. Expiration Date: Click or tap here to enter text.

APN Certification (include specialty): Click or tap here to enter text. Expiration Date: Click or tap here to enter text.

Michigan MD or DO License Number: Click or tap here to enter text. Expiration Date: Click or tap here to enter text.

Specialty Board Certification: Click or tap here to enter text.

Graduate Degree: Click or tap here to enter text.

Major: Click or tap here to enter text. Date Received: Click or tap here to enter text.

Graduate Educational Institution: Click or tap here to enter text.

Undergraduate Degree: Click or tap here to enter text.

Major:Click or tap here to enter text. Date Received: Click or tap here to enter text.

Undergraduate Educational Institution: Click or tap here to enter text.

**(Please attach your CV/Resume and business card to this form)**

Are you **employed** by a health system? [ ] Yes [ ]  No Name: ­­Click or tap here to enter text.

Are you **credentialed** by a health system? [ ] Yes [ ]  No Name: ­­­­­­­­­­­­­­­­­Click or tap here to enter text.

I agree to act as preceptor for Click or tap here to enter text. for **up to** Click or tap here to enter text. **hours**.

 Student’s Name Up to 210 hours or 280 in NRS 6767

**Preceptor Signature:** Date: Click or tap here to enter text.

**Please return (email preferred) to the Clinical Department:**

**Oakland University School of Nursing**

**Clinical Department**

**433 Meadow Brook Rd**

**Rochester, MI 48309**

**npclinical@oakland.edu**