THE UNIVERSITY OF TEXAS AT EL PASO
COLLEGE OF NURSING

Graduate Program

MSN Student Preceptor Approval

I, _____, agree to precept student, _____, in his/her
Preceptor Student
clinical rotation at _____
Clinical Site
For the _____ semester. I understand that prior to him/her starting his/her clinical rotation, we need to establish an Affiliation Agreement between the school and facility and need to be granted approval by program director. By signing at the bottom of this form I acknowledge to the best of my knowledge that the following information is correct.

Preceptor Name: _____

Population/Specialty focus area of practice: _____

Years of practice in this population/specialty: _____

Number of students precepting concurrently: _____

Preceptor Credentials and Certifications: _____

Preceptor Professional License: State, Number and Expiration Date*:

_____

Preceptor Phone Number: _____

Preceptor Email: _____

*Attached are a copy of Preceptor's: CV and Professional License (If available)

Preceptors Signature: _____ Date: _____

Approved by NP Director: Yes No Initials: _____ Date: _____