



FAMILY NURSE PRACTITIONER
College of Nursing & Health Sciences

\*\*\* Clinical Placement Planning Forms\*\*\*

The packet consists of 5 pages. Students are responsible for completion of these forms. Only completed forms will be accepted. NOTE: YOUR PRECEPTOR SHOULD ONLY BE ASKED TO REVIEW and SIGN forms.

Scan and email complete forms to msnclinical@gsw.edu

PART A – STUDENT INFORMATION

Student Name (Last) (First) (Middle)

Complete Permanent Address (Street or PO Box)

(City) (State) (Zip Code) (County)

Contact Information with area codes: Cell Phone

Home Phone Work phone

Personal Email or Other contact information

(print if handwritten)

GSW EmailAddress

Current RN licensure: State(s) #(s) Expiration date

COURSE INFORMATION

-Please mark-

Course Number: Number of clinical hours required in parenthesis

NURS 6421 Assessment (45) NURS 6422 Pri Care of Adults I (135) NURS 6423 Pri Care of Adults II (135)

NURS 6424 Pri Care of Adults III(135-Ped 45-OB) NURS 6425 Practicum (270)

Term & Year: SPRING 20 SUMMER 20 FALL 20

FNP Student Signature

(Date)



**PARTB – PRECEPTOR INFORMATION**  
(Must be completed in full. All information is confidential)

Student Name: \_\_\_\_\_  
(Last) (First) (Middle)

Preceptor Name: \_\_\_\_\_  
(Last) (First) (Middle)

Have you used this preceptor before?  Yes  No

Please mark your status as a preceptor for GSW College of Nursing: **NEW** \_\_\_\_\_ **Established** \_\_\_\_\_  
**(Please attach CV or Resume )**

Credentials (mark one): NP  PA  DO  MD  CNM  Other

License Number \_\_\_\_\_ State \_\_\_\_\_ Expiration Date \_\_\_\_\_

Certification Agency \_\_\_\_\_ Expiration Date \_\_\_\_\_

Years in current role \_\_\_\_\_ Best phone number to contact \_\_\_\_\_

Email address: \_\_\_\_\_

**I agree to serve as preceptor for the student requesting my supervision:**

**Preceptor's Signature**

*If your state requires a delegation for your preceptor, enter the name of the:*

Delegating Physician \_\_\_\_\_  
(Last) (First) (Middle)

his/her Certification \_\_\_\_\_ Expiration date \_\_\_\_\_

Certifying Agency \_\_\_\_\_

**Specialty of Physician Preceptor** (mark the most accurate)

- Cardiology       Geriatrics       Neonatology       Obstetrics
- Women's Health       Emergency Medicine       Gynecology       Neurology
- Pediatrics       Family Practice       Internal Medicine       Oncology
- \_\_\_\_\_ Other (provide specialty): \_\_\_\_\_

**Certification of Nurse Practitioner** (mark the most accurate):

- Adult-Acute       Family       Geriatrics
- Medical-Surgical       Midwifery
- Peds Primary       Women's Health      Other \_\_\_\_\_



**PART C – PRECEPTOR’S PRACTICE INFORMATION**

(Must be completed in full)

Student Name \_\_\_\_\_

(Last)

(First)

(Middle)

**Clinic/Agency Preceptor’s Information**

**Clinic/Agency Name:** \_\_\_\_\_

**Clinic/Agency Street Address:** \_\_\_\_\_

(clinic location – number and street)

\_\_\_\_\_  
(City) (State) (Zip Code) (County)

**Office Manager:** \_\_\_\_\_

*(print if handwritten)*

**Email Address** \_\_\_\_\_

*(print if handwritten)*

Telephone with area code \_\_\_\_\_ Fax Number \_\_\_\_\_

**Orientation of student required by clinical site:** \_\_\_\_\_ YES \_\_\_\_\_ NO

**Orientation contact Email (if required)** \_\_\_\_\_

*(print if handwritten)*

**Clinic/Agency Mailing Address (if different from street address):** \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code) (County)

**The Legal Name of the clinic, group or physician who owns the practice:** \_\_\_\_\_

(Note: Legal name and clinic name may or may not be the same)

**Person Legally Authorized to Sign Contracts:**

**Name** \_\_\_\_\_

(Last)

(First)

(Middle)

**Complete Mailing Address** \_\_\_\_\_

(Street or P.O. Box)

\_\_\_\_\_  
(City) (State) (Zip Code) (County)

Telephone Number with area code \_\_\_\_\_ Fax \_\_\_\_\_

**Email** \_\_\_\_\_

*(print if handwritten)*

**PART D – CONTRACT WITH GSW & CLINICAL SITE**

This clinical site has an existing MOU with GSW under the name of:

\_\_\_\_\_ *expiration date* \_\_\_\_\_.

If your clinical site does not have an existing MOU with GSW, please complete the semester contract below:

\_\_\_\_\_ *Clinical site name* \_\_\_\_\_

\_\_\_\_\_ *City* \_\_\_\_\_ *state* \_\_\_\_\_ *zip* \_\_\_\_\_

and the College of Nursing and Health Sciences at the Georgia Southwestern State University, Americus, Georgia, when appropriate signatures have been affixed below by Dr. Sandra Daniel, Dean of the College of Nursing and Health Sciences, and the authorized agency representative for the clinical site.

The agreement will grant permission to \_\_\_\_\_ *Student name* \_\_\_\_\_

a student enrolled in the Family Nurse Practitioner program at GSW to obtain part of his/her clinical experience through this facility.

The student will work with \_\_\_\_\_ *Preceptor name and title* \_\_\_\_\_ as preceptor.

**The term of the agreement will be:**

- \_\_\_\_\_ **Spring semester:** January 1, \_\_\_\_\_ through April 30, \_\_\_\_\_
- \_\_\_\_\_ **Summer semester:** May 1, \_\_\_\_\_ through July 15, \_\_\_\_\_
- \_\_\_\_\_ **Fall semester:** August 1, \_\_\_\_\_ through December 15, \_\_\_\_\_

If the terms of this agreement are acceptable to you and your agency, please sign below and keep a copy for your records.

\_\_\_\_\_ *SIGNATURE of Person Legally Authorized to Sign Contracts* \_\_\_\_\_ *Date* \_\_\_\_\_



Sandra D. Daniel, PhD, RN Dean and Professor, College of Nursing and Health Sciences



For use in NURS 6425 PRACTICUM only

PARTE – AFFILIATED HOSPITAL INFORMATION

Complete this form only if you will be doing your clinical rotation with patients in the hospital in collaboration with your preceptor.

Hospital Information:

Legal Name of Hospital \_\_\_\_\_ (This must be the hospital affiliated with preceptor for the specified term)

Projected Effective Date of Contract \_\_\_\_\_ (Beginning of specified term)

Chief Nursing Administrator or Education Coordinator with title: \_\_\_\_\_

\_\_\_\_\_  
(Last) (First) (Middle)

Complete Mailing Address \_\_\_\_\_

\_\_\_\_\_  
(Street or P.O. Box)

\_\_\_\_\_  
(City) (State) (Zip Code) (County)

Telephone Number with area code \_\_\_\_\_ FAX \_\_\_\_\_

Person Legally Authorized to Sign Contracts:

Name with title \_\_\_\_\_

Complete Mailing Address \_\_\_\_\_

\_\_\_\_\_  
(Street or P.O. Box)

\_\_\_\_\_  
(City) (State) (Zip Code) (County)

Telephone Number with area code \_\_\_\_\_ FAX \_\_\_\_\_

Email \_\_\_\_\_

(print)