



FAMILY NURSE PRACTITIONER
College of Nursing & Health Sciences

*** Clinical Placement Planning Forms***

The packet consists of 4 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 Email Address

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

COURSE INFORMATION

-Please mark-

Course Number: Number of clinical hours required in parenthesis

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

NURS 6424 Pri Care of OB and Pediatric Population (150-Peds) 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 a signed 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 _____

Number of Patients seen by Preceptor per day:# _____

Age Range of Patients seen by Provider: _____

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