APRN CLINICAL PLACEMENT PLANNING FORM

STUDENT INFORMATION

Please type or print, illegible or incomplete forms will be returned

Student Name: _____

Address: _____

_____

City State Zip Code

Email Address: _____

Primary Phone # _____ Secondary Phone # _____

Areas worked as an RN and number of years: _____

Languages spoken: _____

COURSE INFORMATION

Course Number: _____ Term & Year: _____

Dates will be in clinic: _____

_____ _____

APRN Student Signature Date

Clinical Packet up to date (approval by faculty needed)

_____ _____

WCU Faculty Signature Date

PRECEPTOR INFORMATION

Preceptor Name: (printed) _____

Credentials (MD, DO, NP, CNM, PA):

License Number: _____ Expiration Date: _____

Preceptor Specialty: _____

Years in current role: _____ Best phone number to contact: _____

Email Address: _____

I agree to serve as preceptor for _____
(Student Name)

_____ _____
Preceptor's Signature Date

***Attach preceptor's current resume/CV to this form**.

CLINIC/AGENCY PRACTICE INFORMATION

Clinic/Agency ***Legal Name***, group or physician who owns the practice:

_____

Clinical/Agency Address: _____

Office Manager Name: _____

Telephone Number: _____

Office Manager Email Address: _____

Note: *Clinical placement requires a legal contract between the clinical agency and West Coast University. Completion of this form does not guarantee clinical placement.*