GEORGIA SOUTHWESTERN SCHOOL OF NURSING

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 (150) _____ NURS 6423 Pri Care of Adults II (150)

_____NURS 6424 Pri Care of Pediatric Population (180) _____NURS 6425 Practicum (300)

Term & Year: _____SPRING 20_____ _____SUMMER 20_____ _____FALL 20_____

_____ _____
FNP Student Signature (Date)

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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_____

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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)

GSW
GEORGIA SOUTHWESTERN
SCHOOL OF NURSING

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. Courtney Ross, 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 _____ **as preceptor.**
Preceptor name and title

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**

Courtney B. Ross

Dr. Courtney B. Ross, RN, CNL, NE-BC
Dean, College of Nursing & Health Sciences