**PRECEPTOR INFORMATION FORM**

***Note: Please Attach Preceptor Resume or CV***

Date: _____ Name (please print): _____

Credentials: _____ Position Title: _____

**AGENCY AFFILIATION, NAME AND ADDRESS**

_____

_____

Street address City State Zip Code

Telephone No.: _____

Fax No.: _____

E-Mail Address: _____

Types of patients seen at your clinical site: *(Circle all that apply):*

Pediatric Adolescent Women *(age 18 & up)* Men *(age 18 & up)*

**EDUCATION:**

Nursing Degree *(Circle all that apply):*

BSN MSN Masters *(non-Nursing)* - Specify:

PhD *(Nursing)* DNP PhD *(non-Nursing)* - Specify:

CNS - Specialty: NP - Specialty:

License No: _____ State: _____ Expiration Date: _____

Physician *(Circle all that apply):*

M.D. D.O. Physician's Assistant

Certificate: License Degree

**I agree to function as a clinical/residency preceptor for the School of Nursing at Georgia State University. I have reviewed the SON Preceptor Manual and accept the role and function as a preceptor.**

**Signature:** _____

***Form, along with Resume or CV, may be returned to lwilliams106@gsu.edu or faxed to ATTN: Lisa Y. Williams at 404-413-1205. You may also return via student or clinical faculty.***