## ANGELO STATE UNIVERSITY

## **Department of Nursing**

## **Preceptor Profile (Please include current CV)**

Student Name:	_Course NUR	Semester	
PRECEPTOR NAME		DATE	
Professional License Number	Expiration Date _		
Issuing State Agency			
Agency/Practice Name			
Office Address			
Office City	State	Zip	
Age Range of Patients Service:			
Average Number of Patients per Day:			
Estimated Number of Pediatric Patients per	day (if Family Practice)		
Estimated Population Focus:% Cauca	isian% Hispanic	_% African American	% Other
Estimated Payment Types:% Medicaid _	% Medicare % Priva	ate Insurance% Se	lf
Preferred Method of Contact (Check One)			
☐ Phone Number:			
☐ Email Address:			
CONTACT PERSON IN YOUR AGENCY			
CONTACT PERSON'S PHONE NUMBER			
CONTACT PERSON'S FAX NUMBER			
Would you be interested in offering guest le If so, please list topics.		•	no 
NAME		DATE	

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PLEASE RETURN TO: Graduate Secretary

325-486-6875 or 325-942-2236 (fax)

MAIL: Department of Nursing

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