

Student Name: \_\_\_\_\_

Semester & Year \_\_\_\_\_

Course: \_\_\_\_\_

Instructor \_\_\_\_\_

**Angelo State University  
Department of Nursing  
Preceptor Agreement**

The purpose of this agreement is to permit students in the nursing program at Angelo State University, to participate in a preceptorship within your agency. This form is for the LVN-RN Hospital Partnership Program.

**Conditions of Preceptorship:**

1. I, the preceptor, will include \_\_\_\_\_ clock hours to be scheduled as follows:  
\_\_\_\_\_ for the course \_\_\_\_\_.
2. The student will be under the supervision of an agency employee acting as preceptor.
3. The student will work with me in accomplishing goals identified by the student and faculty that are in accordance with course objectives.
4. I understand that the faculty member will have primary responsibility for the student's clinical learning experience and will serve as liaison between the Department of Nursing and agency.
5. I have read, understand and agree with the responsibilities, policies, and nursing education philosophy noted in the Preceptor Handbook, the Student Handbook, and the "Contract of Association."

Preceptor Name (**Please print**): \_\_\_\_\_

License #: \_\_\_\_\_ State: \_\_\_\_\_ Expires: \_\_\_\_\_ Educational Degrees: \_\_\_\_\_

Title: \_\_\_\_\_ Agency: \_\_\_\_\_

Address: \_\_\_\_\_  
Street/Box City State Zip

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

<b>Student Information</b>	
Home Telephone #: _____	Email: _____
Work/Cell #: _____	

Preceptor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Faculty Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE RETURN TO: Annalisa Santiago  
FAX: (325) 942-2236  
MAIL: Department of Nursing  
ASU Station #10902  
San Angelo, TX 76909-0902

<u>For college use only (date &amp; initial)</u>
Contract with agency/site _____
Copy mailed to preceptor/site _____
Signed & filed _____
Preceptor biography on file _____

**ANGELO STATE UNIVERSITY**  
**Department of Nursing**  
**Preceptor Biographical Data Sheet**  
**FAX: (325) 942-2236**

PRECEPTOR NAME \_\_\_\_\_ DATE \_\_\_\_\_

CREDENTIALS (e.g. MSN, RN, CNS, MD) \_\_\_\_\_

PROFESSIONAL LICENSE NUMBER \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

ISSUING STATE AGENCY \_\_\_\_\_

CERTIFICATION    yes    no    BY WHOM \_\_\_\_\_ EXP \_\_\_\_\_

SPECIALTY \_\_\_\_\_ EMAIL \_\_\_\_\_

INSTITUTIONAL AFFILIATION \_\_\_\_\_

OFFICE ADDRESS \_\_\_\_\_

OFFICE CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

OFFICE PHONE NUMBERS – VOICE \_\_\_\_\_ FAX \_\_\_\_\_

PREFERRED METHOD OF CONTACT (Check one)

PHONE # \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PREFERRED TIME OF CONTACT

DAY (Circle one): MON    TUE    WED    THURS    FRI    ANY WEEKDAY

TIME: \_\_\_\_\_

CONTACT PERSON IN YOUR AGENCY \_\_\_\_\_

CONTACT PERSON'S PHONE NUMBER \_\_\_\_\_

**This material is kept secured at the ASU Department of Nursing and remains confidential.**

.....

PLEASE RETURN TO: Annalisa Santiago  
FAX:                (325) 942-2236  
MAIL:              Department of Nursing  
                      ASU Station #10902  
                      San Angelo, TX 76909-0902

NAME \_\_\_\_\_ DATE \_\_\_\_\_

**SCHOLASTIC BACKGROUND**

College or University Degree Date

_____	_____	_____
_____	_____	_____
_____	_____	_____

Graduate or Professional School

_____	_____	_____
_____	_____	_____
_____	_____	_____

**ORGANIZATIONS AND PROFESSIONAL ASSOCIATIONS**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**This material is kept secured at the ASU Department of Nursing and remains confidential.**

PLEASE RETURN TO: Annalisa Santiago  
FAX: (325) 942-2236  
MAIL: Department of Nursing  
ASU Station #10902  
San Angelo, TX 76909-0902

9/07, 07/08