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| **Student information** | | | | | | | | | | | | | | | | | | | | | |
| **Student Name:** | | |  | | | | | | | | | | **Course Name:** | | | | |  | | | |
| **Student Email:** | |  | | | | | | | | | | | **Course Number:** | | | | |  | | | |
| **Dates of Clinical Experience:** | | | | | |  | | *through* | | |  | | | |
| **Clinical Site Name:** | | | |  | | | | | | | | | | | | **Phone:** | | | |  | |
| *Clinical site agency affiliation, if applicable:* | | | | | | |  | | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | | | | | | | | | | | | |
| City: |  | | | | | | | | | | | State: | |  | | | | | Zip: | |  |
| **Preceptor information** | | | | | | | | | | | | | | | | | | | | | |
| **Preceptor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preceptor Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preceptor Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_  **Preceptor Prof. License #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Type of License:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Licensing Agency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Issuing State:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does preceptor have at least 2 years of relevant preceptor experience?  **Yes ☐ No☐**  List relevant experience pertaining to student’s area of focus:*(i.e. Leadership, management, policy, Peds, NP, women’s health, gero)*  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Areas of Certification: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Is Preceptor the Student’s Direct Supervisor at work (student’s place of employment)?  **Yes ☐ No☐**  Has the Preceptor previously precepted for Mennonite College of Nursing students? **Yes☐ No☐** | | | | | | | | | | | | | | | | | | | | | |
| ***I agree to serve as a preceptor as noted above:*** | | | | | | | | | **SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
|  | | | | |  | | | | | *To be signed by preceptor* | | | | | | |  | | | | |

**Continue to page 2**

**Affiliation Agreement preparation information**

The information provided on this page (page 2) should be of the person legally authorized to sign an affiliation agreement contract for the site where clinical hours will be completed by the student. For example, Education Coordinator, Legal Representative, or HR Representative. Please include all information requested below.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Site Name

Name and all contact information of person authorized to sign affiliation agreement contracts

1. Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address, City, State, Zip Code

***All information requested on this form must be completed or it will not be processed and will be returned to you for completion. Both pages 1 and 2 must be completed and submitted to the MCN Instructional Experience Coordinator at*** [***mcnpostlicensureclinical@ilstu.edu***](mailto:mcnpostlicensureclinical@ilstu.edu)

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| --- | --- | --- | --- | --- |
| **FOR OFFICE USE ONLY** | | | | |
| Date received: |  | INITIALS: | Course dates confirmed: Y ☐ N☐ License verified: Y ☐ N☐ Affiliated Agreement current: Y ☐ N☐ | |
| *If Yes* - Practice site agreement expiration date: | | | | **FORM APPROVED:** |
| *If No -* Status of contract agreement process: | | | | New agreement activation date: |