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| **Deadlines for Preceptor Agreement Form Completion** | ***Questions?***Contact the Instructional Experience Coordinator:(309) 438-1403 or your Sequence Leader |
| Fall Semester – Due May 15thSpring Semester – Due October 15th | Summer Session – Due March 15th |

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| --- | --- | --- | --- |
| **Student Name:**  |  | **Course Name:**  |  |
| **Student Email:** |  | **Course Number:** |  |
| **Dates of Residency Experience:** |  | ***through*** |  |
| **Practice Site Name:** |  | **Phone:** |  |
| *Practice site agency affiliation, if applicable:* |  |
| Address: |  |
| City: |  | State: |  | Zip: |  |
| **Preceptor Printed Name:** |  | Credentials: |  |
| **Preceptor Title/Position:** |  | Email Address: |  |
| Phone (not required): |  | Prof. License #  |  | State: |  | Expires: |  |
| **Board Certification: Yes ☐ No☐** | If yes, Certifying Board: |  | Date Certified: |  |
| **Areas of Certification:** |  |
| *I agree to serve as a preceptor as noted above:* **Signature:** |  | **Date:** |  |
|  |  |  |  |
| Has the Preceptor previously precepted for Mennonite College of Nursing students? **Yes☐ No☐** |
| Has any MCN student been to this facility in the past with any preceptor? **\*\* Yes☐ No☐**\*\* |
|  |  |  |

\*\***If no, please complete *at least #1 and 2* on the section on the back of this form. If yes, the back page may be left blank.**

**When completed, submit form to the Instructional Experience Coordinator.
Form can be mailed in or faxed directly to (309) 438-2620.**

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| **FOR OFFICE USE ONLY** |
| Date form received: |  | INITIALS: | Start/End dates confirmed  | Y ☐ N☐ |
| License Verification: Y ☐ N☐ | Preceptor CV on File: Y ☐ N☐ |
| Practice site Affiliated Agreement confirmed and verified as current: | Y ☐  N ☐ | If Yes: Practice site agreement expiration date: |
| If No:  | Status of contract agreement process: |
|  |
| New agreement activated: | Date: | Expiration: |

**Affiliation Agreement preparation information**

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

Legal Name of Agency to Appear on Contract between MCN and Clinical Agency

1. **\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Phone: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name and Title of Contact Person for Contract between MCN and Clinical Agency *(Please add email if known)*

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

Name and Title of Person Legally Authorized to Sign Contract for Clinical Agency *(if different than #2 above)*

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

Phone Number and Clinical Agency of Person listed on Line #3 above *(if different than #2 above)*

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

Name of Person to Whom the Clinical Agency Contract should be mailed *(e.g., Office Manager, Administrative Assistant)*

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

 Mailing Address, City, State, Zip Code