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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 15th  Spring 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