ILLINOIS STATE UNIVERSITY
Mennonite College of Nursing

Preceptor Agreement Form

Deadlines: Fall Semester. – Due May 15th
Spring Semester – Due October 15th
Summer Session – Due March 15th

STUDENT INFORMATION

Student Name: _____ **Course Name:** _____

Student Email: _____ **Course Number:** _____

Dates of Preceptor Experience: _____ *through* _____

Practice Site Name: _____ **Phone:** _____

Practice site agency affiliation, if applicable: _____

Address: _____

City: _____ State: _____ Zip: _____

PRECEPTOR INFORMATION

Preceptor Name: _____ **Highest Degree**: _____

Preceptor Phone: _____ Preceptor Email: _____

Is Preceptor Student's Direct Supervisor? Yes ☐ No☐

Preceptor Prof. License #: _____

Is Preceptor Board Certified? Yes ☐ No☐ Issuing State:_____ Expires: _____

If yes, Certifying Board: _____ *Areas of Certification:* _____

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. NP, women's health, gero, management, leadership)

_____

_____

I agree to serve as a preceptor as noted above: **SIGNATURE:** _____ **Date:** _____
To be signed by preceptor

(Filled out by student)

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 page 2 of this form.*
If yes, the back page may be left blank.

When complete, please fax form to MCN Instructional Experience Coordinator (309) 438-2620, or send direct mail.

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:**	

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If No - Status of contract agreement process:	New agreement activation date:

Affiliation Agreement preparation information *(fill in at least #1 and #2)*

1. *_____
Legal Name of Agency to Appear on Contract between MCN and Clinical Agency

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

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

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

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

6. _____
Mailing Address, City, State, Zip Code