MENNONITE COLLEGE OF NURSING
ILLINOIS STATE UNIVERSITY
PRECEPTOR AGREEMENT FORM

Student Name ______________________________________ Course Name & Number ______________________________

Starting Date for Clinical Experience _____________________ End Date for Clinical Experience _____________________

Preceptor Printed Name ____________________________________________ Credentials ____________________________

Preceptor Title/Position ________________________________________ Email Address ________________________________

Practice Site:
Name _______________________________________________________________________________________

Address ______________________________________________________________________________________

State ______ Zip ______ Phone (work) ________________ Phone (home) __________________ Fax ________________

Professional License: # ________________________________ State __________ Expiration Date_______________________

Total Number of Years Experience at Current Level of Licensure __________________________________________

Board Certification: No Yes If yes, Certifying Board ____________________________________________________

Area(s) of certification ______________________________________________ Date Certified: __________________

I agree to serve as a preceptor as noted above: ________________________________________________________ (Signature)

Has the Preceptor previously precepted for Mennonite College of Nursing students?  Yes  No
If no, please complete this section. If yes, then this section may be left blank.

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

2. ____________________________________________________________
   Name and Title of Contact Person for Contract between MCN and Clinical Agency
   Phone: __________________

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

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

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

Mailing Address, City, State, Zip Code

FOR OFFICE USE ONLY

Date Entered
By (initials)