

**BSU School of Nursing
Clinical Preceptor Information**

Student Name: _____ Course # _____ Semester: _____

Preceptor Name and Credentials: _____

Agency Name _____

Office Name _____

Mailing Address: _____

City _____ State _____ Zip _____

Office Phone: (____) _____ Fax: (____) _____

E-mail Address: _____

Education (include institution, degree(s), and year of graduation):

Practice Specialty: _____

Years of experience in Specialty Area: _____

State licensure number and expiration date: _____

Do you have national NP or CNS certification? Yes ____ No ____

Attach copy of current national NP/CNS certification

Have you previously precepted graduate students? Yes ____ No ____

Type of agency/site (private practice, public health, etc): _____

Average number of clients seen per day: _____ Client age range: _____

Services provided: _____

The **student** is responsible for submitting **all** pre-clinical forms and documents (see Pre-Clinical Information Checklist, Form # 14) together in **one** envelope by the designated due date. Mail to: Graduate Program Secretary, School of Nursing, Ball State University, Muncie, IN 47306-0265.

DO NOT fax any forms or documents.

If your preceptor has any questions about the course, please have them contact the course faculty.