



THE UNIVERSITY OF TOLEDO

APRN Preceptor Agreement Form

Instructions: Student, complete the top portion of this form and deliver to your preceptor to complete. You cannot begin a clinical experience until this form is completed, signed & returned electronically to: APRNplacements@utoledo.edu

Today's Date: _____ Semester of Clinical: _____ Year of Clinical: _____

Course #: _____ Number of clinical hours requested: _____

Student Full Name: _____
(As it appears on RN license)

Student Tel. #: _____ Student Email: _____ Student License #: _____

Student signature: _____

Instructions: Preceptor, complete this portion of the form and return to the student.

Preceptor Full Name _____
(As it appears on professional license)

Title: _____ Discipline: _____ Credentials: _____

Certification: _____ Education: _____

Clinical Specialty Area: _____ Years in Advanced Role: _____

License/Endorsement #: _____ No. of students you are supervising this semester concurrently per day: _____

Preceptor email: _____

Name of Agency/Clinical Practice Site: _____

Address: _____ City: _____ State: _____ Zip: _____

Site Office Tel. #: _____

Type of site (e.g. primary care, acute care, long-term care): _____

Types of patients seen at site (e.g., child, adult, older adult or across the lifespan): _____

Number of clinical hours agreed upon: _____

Preceptor signature: _____ Date: _____

For College Of Nursing Use Only

Typhon - Student _____
Site _____
Preceptor _____

License - Student _____
Preceptor _____
Health _____

Active Contract _____
Green Light Given _____