**Preceptor Approval Form & Agreement**

*St. David’s School of Nursing, Texas State University*

Please enter the requested information in the blanks provided. When possible, students should fill in as much of the information as they can before giving it to the preceptor to complete.

Student Name: ___________________ Semester and Year: _______________ Course #: __________

### Preceptor Information

| Name: __________________________ | Email *(required)*: __________________________ |
| Clinic Name: ____________________ | |

**For providers other than MD’s only:**

| License #: __________________________ | Expires: __________________________ |
| For MDs/DOs only: ____________________ | Expiration: __________________________ |
| Medical License #: ____________________ | Expiration: __________________________ |

**For PAs only (if preceptor is a PA, the supervising physician must provide their license and expiration date above):**

| PA License #: __________________________ | Expires: __________________________ |

### Experience:

| Area of Practice: __________________________ | Years in Area: _______________ |
| Highest Nursing/Medical Degree: __________________________ |

Are you willing to precept the student named above and sign paperwork for the student?  
Yes _______ No _______

Are you willing to read the Preceptor Handbook (8 pages), which serves as orientation to TxState’s MSN program?  
Yes _______ No _______

Are you willing to participate in student evaluation twice per semester (at midterm and final)?  
Yes _______ No _______

How many other students will you be precepting concurrently? __________________________

Are you willing to precept TxState MSN students in future semesters?  
Yes _______ No _______

If you answered yes, please note if you are only available during certain times of the year below: __________________________

*(2 years of employment experience is required. Please attach required resume, CV, or portfolio)*

Preceptor Signature __________________________ Date: _______________

(actual signatures required)

Please return to the student. Students, please email upload your form to Typhon.

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Office Use Only

License Validated ☐  Approved ☐  Not Approved ☐

____________________________________  ______________________
Faculty Signature                      Date