2500 North State Street
Jackson, MS 39216-4505
(601) 984-6255 ● (601) 984-6211

PRECEPTOR AGREEMENT

STUDENT NAME: ____

PRECEPTOR/FACILITATOR NAME: ____

CREDENTIALS: ____

LICENSE NUMBER: _________________________ EXPIRATION DATE:____________________

AGENCY NAME: ____

AGENCY ADDRESS: ____

CITY/STATE/ZIP: ____

PHONE:____________________FAX:____________________EMAIL:_______________________

Please list all degrees and certifications held. Also list any certifications or other advanced preparation in the field.

Degree/Certification	Year Awarded	Main Field of Study	Educational Institution/Organization

Current Position (unit/dept./floor) -- Work Experience (last 5 years) and/or Area of Expertise

____

____

____

Do you have malpractice insurance? ______ YES _______NO

I hereby _________ **AGREE** ________ **DISAGREE** to serve as a preceptor for the above referenced student.

____

Signature Date

It is the student's responsibility to ask the preceptor whether the manager and/or HR Department needs to be contacted prior to starting their clinicals

COURSE NUMBER: ______________SEMESTER: ____________ACADEMIC YEAR: ___________

Preceptor/Facilitator Agreement Form: October 2017
Revised: Jan 18; Feb 18; Jan 19