

CALIFORNIA STATE UNIVERSITY, BAKERSFIELD
 Department of Nursing
 Family Nurse Practitioner Program

Verification of Contract for Family Nurse Practitioner Placement

| | |
|--|---|
| Name of Student: | _____ |
| Course Number: | _____ |
| Semester/Year: | _____ |
| Name of Agency: | _____ |
| Address of Agency: | <div style="border: 1px solid black; height: 30px; width: 100%;"></div> |
| Telephone/Agency: | _____ |
| Fax/Agency: | _____ |
| Name of Preceptor: | _____ |
| Preceptor Email | |
| (for the Administrative Support Coordinator at the Department of Nursing to complete) | |
| Verification of Contract: | Yes ____ No ____ Initiated but not signed ____ |
| Date of Contract: | _____ Expiration Date of Contract: _____ |
| Verified by: | _____ Date: _____ |
| Please return to instructor after verification of contract has been completed by Nursing Department staff. | |
| Name of Instructor: | _____ |
| Signature of Instructor: | _____ Date: _____ |

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Confirmation of Agreement to Precept

I, _____ (**Printed name of Preceptor**) have met with the graduate student regarding a preceptorship at this agency. I have reviewed the preceptorship agreement, and we have discussed the course objectives, clinical requirements, and the FNP Student Evaluation document for _____ (**course number**) and agree to act as Clinical Preceptor to _____ RN (**Printed name of Graduate Student**) as part of his/her enrollment in the CSUB Graduate Nursing Program clinical course. I am aware that I will need to confer with the Clinical Instructor during and at the end of the Semester to provide any information I believe is necessary regarding the student's progress in the clinical practicum. A written evaluation of the student, on the provided form should be submitted at the end of the Semester.

I meet the following minimum qualifications to precept this student:

- Possession of a current California license to practice as a physician or nurse practitioner.
- A copy of my California License to Practice is available at my facility.
- At least one year of clinical experience either as a physician or nurse practitioner providing primary care.
- In a group practice, any other provider participating in supervision of the student must also meet the same qualifications with regard to education and clinical experience.

I am willing to serve and be available as a preceptor for this student enrolled in the above named course during the period of _____ (Semester), in _____ (year).

I am also aware that I must complete the FNP Student Evaluation document prior to the end of the Semester in which this student is enrolled.

Preceptor (Print): _____

Telephone: _____ FAX: _____

Most convenient time to call: _____

Email: _____

Agency: _____

Address: _____

City/State: _____ Zip: _____

Preceptor's Signature Date

CALIFORNIA STATE UNIVERSITY, BAKERSFIELD
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Preceptor Profile Form: Biography/Curriculum Vitae

Name: _____ Credential(s): _____
 License # _____ Expiration Date: _____
 Area of Specialization: _____ Years of Experience: _____
 Facility: _____ Business Address: _____
 Work Phone: _____ Work Fax: _____
 Email Address: _____

Education: List your basic medical/nursing education/advanced education as a physician or in nursing or other fields

| Name of College | Location | Degree Earned | Dates of Attendance |
|-----------------|----------|---------------|---------------------|
| | | | |
| | | | |

Certifications: List any certifications that you hold.

| Name of Certification | Organization Providing Certification | Dates of Certification |
|-----------------------|--------------------------------------|------------------------|
| | | |
| | | |

Clinical Experience: List your most recent clinical experience other than your present employment.

| Name of Employer | Job Title/Responsibilities | Dates of Employment |
|------------------|----------------------------|---------------------|
| | | |
| | | |
| | | |

Professional Honors and Awards: List any special professional honors/awards you have received (e.g., Sigma Theta Tau and other professional organizations; conference presentations; scholarships; publications; recognition).

Preceptor Experience: List prior preceptor experience with CSUB, other colleges, hospitals, & health care organizations

| Name of Organization | Type of Student | Dates/Length of Preceptorship |
|----------------------|-----------------|-------------------------------|
| | | |
| | | |

*In lieu of completing this section, attach your curriculum vitae documenting this information.

PLEASE RETURN TO:
 California State University, Bakersfield
 Attn: Administrative Support
 Department of Nursing
 29 RNC
 9001 Stockdale Highway
 Bakersfield, CA 93311-1022