**PRECEPTOR AGREEMENT FORM- FAMILY NURSE PRACTITIONER TRACK**

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 Family Nurse Practitioner student evaluation document for the practicum courses. I agree to act as a Clinical Preceptor to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RN (**Printed name of Graduate Student**) as part of his/her enrollment in the Holy Family University Graduate Nursing Program’s clinical course(s). I am aware that I may need to confer with the faculty to provide any information that I believe is necessary regarding the student’s progress in the practicum.

I meet the following minimum qualifications to precept this student:

1. Must hold a current license to practice as a physician or nurse practitioner in the state where the practicum site is located (A copy of my state license to practice is available at my facility)
2. At least one year of clinical experience either as a physician or nurse practitioner providing primary care.
3. I am Board Certified.
4. I maintain professional liability insurance, and the required professional liability insurance coverage in the amount specified in the Board's law and/or regulations. This may be provided by yourself or your employer.

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 practicum course(s) during the \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Year**) academic year.

I am aware that I must complete the Family Nurse Practitioner student evaluation document prior to the end of the semester in which this student is enrolled.

Preceptor (Print): Telephone:

Email: Agency:

Address:

City/State:

Zip:

Preceptor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_