COLLEGE OF NURSING

PRECEPTOR DATA FORM
for Non-Nursing Healthcare Professionals

Preceptor Information: (Please print)

Name: ____ Date :______________________

Credentials: _________________________________ Title: _________________________________

State Licensed in: ______ License #: _________ Expiration: _________ Board Certification #: _________

Preferred Mailing Address:

____

(Address)

____

(City) (State) (Zip)

Contact Info: (*will be available to administration and students*)

Primary Email: ____

Office Phone: ________________ Mobile Phone: _________________ Pager: ______________

Educational Background and Experience:

Educational Background (List all degrees): ____

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Years of professional experience: __________________ Years with current organization: _____________

Specialty areas: ____

Have you taught advanced practice nursing students in a preceptor role in the past? ☐ Yes ☐ No

Facility Information:

Site Name: ____

Physical Address: ____

Business Phone: _____________________________ Business Fax: ______________________________

Facility Demographics:

Facility Type: (Check all that apply) ☐ Rural Clinic ☐ Community Health ☐ Private Practice ☐ Non-profit

Facility experience: (Check all that apply) ☐ Urgent Care ☐ Inpatient ☐ Primary Care ☐ Long term Acute Care ☐ Pediatric Primary Care ☐ OB/GYN ☐ Newborn visits ☐ Behavioral Health ☐ Family Practice

Populations Served: (Check all that apply) ☐ Newborns ☐ Infants ☐ Children ☐ Adolescents ☐ Adults ☐ Women ☐ Geriatrics (Age 65 and older)

Number of beds and/or exam rooms: ____

Maximum number of APN students permitted in unit/facility concurrently:__________________________

Roles and Responsibilities:

Did you receive course and clinical objectives (written or verbal)? ☐ Yes ☐ No

Did you receive orientation (written or verbal) for your role as preceptor? ☐ Yes ☐ No

What additional assistance would be beneficial to support and enhance your role as a preceptor?

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RETURN COMPLETED FORM TO: *HSC-CON-Placements@salud.unm.edu*