

MEDICAL UNIVERSITY OF SOUTH CAROLINA COLLEGE OF NURSING

**Graduate Clinical Preceptor Information Form/Abbreviated CV**

Information required of all Preceptors

Date: \_\_\_\_\_ Student Name: \_\_\_\_\_

Preceptor: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ Practice/Clinical Site: \_\_\_\_\_

Credentials: \_\_\_\_\_

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

**PRECEPTOR DEGREE INFORMATION (Check All that Apply)**

**Type of Degrees:**

- DNP       DNSc/DNP       DO       DrPH       PA  
 EdD       JD       MS/MSN       MA       MBA  
 MD       ND       PharmD       PhD  
 Other: \_\_\_\_\_

**EDUCATION (Baccalaureate and Above)**

Institution	Years Attended	Degree Date	Field of Study
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PRECEPTOR LICENSE INFORMATION:**

Type of License: \_\_\_\_\_ State License Issued: \_\_\_\_\_  
License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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PRECEPTOR CERTIFICATION INFORMATION (Check All that Apply):

Nurse Certification       Physician Certification  
 Pharmacist Certification       Other Certification: \_\_\_\_\_

Current Certification #1: \_\_\_\_\_ Certifying Body: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_ Years in Specialty Area: \_\_\_\_\_

Current Certification #2: \_\_\_\_\_ Certifying Body: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_ Years in Specialty Area: \_\_\_\_\_

EMPLOYMENT: (Chronological for past 5 years)

Institution	Position	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preceptor's Practice Specialty (Check All that Apply)

- Acute Care       Administration       Allergy/Immunology       Anesthesia
- Cardiology       Critical Care       Dermatology       Emergency
- Family Practice       Forensics       Gerontology
- Internal Medicine       Neonatal       OB/GYN       Oncology
- Ophthalmology       Orthopedics       Otolaryngology       Pediatrics
- Psychiatric       Public Health       Surgery       Trauma
- Other: \_\_\_\_\_

Total Number of Students Precepted Concurrently \_\_\_\_\_  
(This includes **All** students, not just MUSC students, and not just nursing students)

I agree to serve as preceptor for \_\_\_\_\_  
(Student)

I have attached my abbreviated CV, Licensure and Certification

\_\_\_\_\_  
Preceptor Signature      Date

\_\_\_\_\_  
Signature of Student      Date