

**PRECEPTOR AGREEMENT AND CREDENTIALS**

**Preceptor:** Please fill out Parts A & B of the Preceptor Agreement form. Sign and return to student of requesting faculty member. Clinical affiliation agreements and preceptor agreements must be in place prior to the student being on site for clinicals.

**PART A:**

Preceptor Name: \_\_\_\_\_

Preceptor Home Address: \_\_\_\_\_  
(Street / City / State / Zip Code)

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Clinical Specialty: \_\_\_\_\_

Name of Facility or Employer: \_\_\_\_\_

TX RN Lic#: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Select All Degrees Held: Undergraduate \_\_\_ Graduate: \_\_\_ Doctoral: \_\_\_ Other: \_\_\_ Certifications: \_\_\_\_\_

If not an RN, please attach all appropriate credentials (Resume and/or CV, certifications)

Please write initials in box if copy of Preceptor Handbook was received: \_\_\_\_\_

**PART B:**

I, \_\_\_\_\_ do agree to act as a preceptor for  
(Print Preceptor Name)

\_\_\_\_\_, in NUR \_\_\_\_\_, who will be  
(Print Student Name) (Course Number)

completing Clinical Rotation at \_\_\_\_\_  
(Location Where Clinical Affiliation Agreement Exists)

*I hereby agree to abide by all the rules and requirements set forth in the Preceptor Handbook:*

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

\_\_\_\_\_  
Student Signature / Date

\_\_\_\_\_  
Faculty Signature / Date

\_\_\_\_\_  
Other Approval (if applicable) / Date

<p><b>For College of Nursing USE ONLY:</b></p> <ul style="list-style-type: none"><li>• BON Verification (Date/Time/Initials): _____</li><li>• UH Clinical Affiliation Agreement Number: _____</li><li>• Justification for Preceptor Qualifications if Preceptor is not an RN: _____</li></ul> <p>_____</p>
--