

California State University, Dominguez Hills  
School of Nursing  
LEARNING CONTRACT

Course number \_\_\_\_\_

Student \_\_\_\_\_

Student ID # \_\_\_\_\_ Last, \_\_\_\_\_ First \_\_\_\_\_  
E-mail address \_\_\_\_\_

Day time phone ( ) \_\_\_\_\_ Evening phone ( ) \_\_\_\_\_

Academic Program: BSN MSN PHN Certificate \_\_\_\_\_  
Type

1. Preceptor's name \_\_\_\_\_ Title \_\_\_\_\_

Phone ( ) \_\_\_\_\_ E-mail Address \_\_\_\_\_

2. Agency \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ZIP \_\_\_\_\_

3. Nursing Administrator / Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

4. CSUDH Course Instructor's name \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

**In case of emergency, contact CSUDH Division of Nursing at (310) 243-3596**

*The number of hours required in each course varies. Please consult the syllabus for the number of hours required.*

The number of hours of clinical experience required for this course is: \_\_\_\_\_

Please schedule hours accordingly.

Beginning Date \_\_\_\_\_ Final Date \_\_\_\_\_

***State personal goals here and complete page two, objectives, learning activities, and evaluation measures.***

Student's signature \_\_\_\_\_ Date \_\_\_\_\_

***Preceptor's signature indicates approval of the Learning Contract and acceptance of the clinical schedule.***

Preceptor's Signature \_\_\_\_\_ Date \_\_\_\_\_

***Instructor's signature indicates approval of preceptor, learning contract and clinic schedule.***

Instructor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Student is to keep a copy of this form, provide a copy to the preceptor, and submit original to instructor.**

**Learning Contract (Cont.)**

| <b>Objectives</b> | <b>Learning Activities</b> | <b>Evaluation measures</b> |
|-------------------|----------------------------|----------------------------|
|                   |                            |                            |