

**CALIFORNIA STATE UNIVERSITY, DOMINGUEZ HILLS**  
**DIVISION OF NURSING**  
**Preceptor Information Form**

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Student Name: \_\_\_\_\_ Course # \_\_\_\_\_  
Student ID #: \_\_\_\_\_  
Preceptor Name: \_\_\_\_\_  
Preceptor Work Address: \_\_\_\_\_  
Preceptor Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Agency or Nursing Administrator \_\_\_\_\_

**Practice Setting (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Acute Care (type: _____) | <input type="checkbox"/> Long-term care       |
| <input type="checkbox"/> Ambulatory Care          | <input type="checkbox"/> Mental Health        |
| <input type="checkbox"/> primary care             | <input type="checkbox"/> Occupational Health  |
| <input type="checkbox"/> specialty clinics        | <input type="checkbox"/> Public Health        |
| <input type="checkbox"/> surgery                  | <input type="checkbox"/> Rehabilitation       |
| <input type="checkbox"/> birthing center          | <input type="checkbox"/> School Health        |
| <input type="checkbox"/> Health Education         | <input type="checkbox"/> Substance Abuse Care |
| <input type="checkbox"/> Home Care                | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Hospice Care             |   |

**You may attach your curriculum vitae in lieu of completing the information requested below:**

Educational preparation: (list schools, dates and degree conferred)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Professional license and/or Certifications (list applicable certificate/ license numbers and registration dates)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Present position and number of years in present position:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_