

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

Course # MSN560: Nurse Administrator Role Performance I

Student Name: _____ 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"/> |
| <input type="checkbox"/> Hospice Care | Other _____ |

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: _____