California State University, Dominguez Hills

School of Nursing

GRADUATE LEARNING CONTRACT

Course Number Select Course

Student Name (last, first) _____

Student ID # _____ CSUDH E-mail Address_____

Day Phone _____ Evening Phone _____

Graduate Program ☐ MSN ☐ Post-graduate Certificate Role Option: Select Option

1. Preceptor Name _____ Title _____

Phone _____ E-mail Address _____

2. Agency Legal Name_____

Address _____

City _____ State _____ ZIP _____

3. Agency Administrator / Contact Person _____ Phone _____

4. CSUDH Role Advisor name Select Role Advisor Phone Select Advisor Phone Number

Email Address Select Advisor e-mail address

In case of emergency, contact the School of Nursing at (310) 243-3596

The number of hours of clinical experience required for this course is: Select Course Hours

Beginning Date _____ Final Date _____

Page 2 outlines the objectives (based on course learning objectives), learning activities to achieve the objectives, and the evaluation measures. Signatures indicate approval of the Learning Contract and acceptance of the clinical schedule.

Student Signature _____ Date _____

Preceptor Signature _____ Date _____

Student is to provide a copy of the full document to the preceptor and submit to Exxat for approval.

Learning Contract (Cont.)

Course Objectives	Learning Activities	Evaluation measures

Preceptor signature: _____