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

Preceptor Name & Credentials: _____

Preceptor Work Address: _____

_____

Preceptor Phone: _____Fax:_____

Preceptor Email: _____

Name of Student Coordinator at Site: _____

Site Student Coordinator Email: _____

Practice Setting (mark all that apply)

- ☐ Acute Care (Type: _____)
- ☐ Ambulatory Care
  - ☐ primary care
  - ☐ specialty clinics
  - ☐ surgery
  - ☐ birthing center
- ☐ Health Education
- ☐ Home Care
- ☐ Hospice Care
- ☐ Long-term care
- ☐ Mental Health
- ☐ Occupational Health
- ☐ Public Health
- ☐ Rehabilitation
- ☐ School Health
- ☐ Substance Abuse Care
- ☐
- Other_____

_____

Educational Preparation (list schools, dates, and degree conferred)

_____

_____

Professional License and Certifications (list license numbers, board certifications, and expiration dates)

_____

_____

_____

Current position (describe position, time in this position, and total years experience in related positions)

_____

_____

Signature: _____ Date:_____

Title: _____