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

Course #_____

Student Name: _____ ID# _____

Preceptor Name: _____

Preceptor Work Address: _____

_____

Preceptor Phone: _____Fax:_____

E-mail Address: _____

Agency or Nursing Administrator: _____

Practice Setting (Check 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_____

_____

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: _____