COLLEGE OF NURSING

PRECEPTOR DATA FORM
for Nursing Professionals

Preceptor Information: (Please print)

Name: _____ Date :_____

Credentials: _____

Preferred Mailing Address:

_____

(Address)

_____

(City) (State) (Zip)

Contact Info: (*Will be available to CON administration and students*)

Primary Email: _____

Office Phone: _____ Mobile Phone: _____ Pager: _____

Select the national certification association/board you are certified by (if applicable):

☐ ANCC ☐ AANP ☐ PNCB ☐ AACN ☐ AMCB

Educational Background and Experience:

Nursing degrees (Check all that apply): ☐ ADN ☐ BSN ☐ MSN ☐ DNP ☐ PhD

UNM CON degrees (Check all that apply): ☐ FNP ☐ PNP ☐ AG-ACNP ☐ CNM ☐ Admin ☐ DNP
☐ Other _____

Specialty areas: _____

Years of practice in your population focused/specialty area(s): _____

Years with current organization: _____

Have you taught advanced practice nursing students in a preceptor role in the past? ☐ Yes ☐ No

Facility Information:

Facility Name: _____

Physical Address: _____

Business Phone: _____ Business Fax: _____

Facility Type: (Check all that apply) ☐ Rural Clinic ☐ Community Health ☐ Private Practice ☐ Non-profit
Facility experience: (Check all that apply) ☐ Urgent Care ☐ Inpatient ☐ Primary Care ☐ Long term Acute Care
☐ Pediatric Primary Care ☐ OB/GYN ☐ Newborn visits ☐ Behavioral Health ☐ Family Practice
Populations Served: (Check all that apply) ☐ Newborns ☐ Infants ☐ Children ☐ Adolescents
☐ Adults ☐ Women ☐ Geriatrics (Age 65 and older)

Number of beds and/or exam rooms: _____

Roles and Responsibilities:

Did you receive course and clinical objectives (written or verbal)? ☐ Yes ☐ No
Did you receive orientation (written or verbal) for your role as preceptor? ☐ Yes ☐ No
What additional assistance would be beneficial to support and enhance your role as a preceptor?

_____

_____

RETURN COMPLETED FORM TO: *HSC-CON-Placements@salud.unm.edu*