LE MOYNE
PURCELL SCHOOL OF PROFESSIONAL STUDIES

MASTER OF SCIENCE FAMILY NURSE PRACTITIONER

PRECEPTOR CONTACT INFORMATION FORM

Preceptor's Name_____ Home Phone (_____) _____

Employer (**Corporate**)_____

Employer's Address: _____

City _____State_____ZIP _____

Work Phone (_____) _____ Work Fax (_____) _____ Other (_____) _____

Email Address_____

New York RN License Number _____ Expiration Date_____

NP Certification (include specialty)_____ Expiration Date_____

New York MD or DO License Number _____ Expiration Date_____

Specialty Board Certification:_____

Graduate Degree: _____ Major: _____ Date Received:_____

Graduate Educational Institution: _____

Graduate Degree: _____ Major: _____ Date Received:_____

(Please attach your CV/ Résumé to this form)

Are you ***employed*** by a health system? ❑ Yes ❑ No Name:_____

Are you ***credentialed*** by a health system? ❑ Yes ❑ No Name: _____

I agree to act as preceptor for _____ for up to_____hours
Student's Name

Preceptor Signature: _____ Date: _____

> Please return to Clinical Coordinator of FNP Program:

Kattiria Gonzalez, MS, RN
Le Moyne College Department of Nursing
Purcell School of Professional Studies
1419 Salt Springs Road, Syracuse, NY 13214