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|  | Oregon State Board of Nursing17938 SW Upper Boones Ferry Road • Portland, Oregon 97224-7012Phone: 971-673-0685 License Verification: 971-673-0679Website: [www.oregon.gov/OSBN](http://www.oregon.gov/OSBN) **All forms must be submitted to OSBN by the educational instituti**on. |

**CLINICAL PRECEPTOR AGREEMENT**

**For Non-Oregon Based Programs**

**Offering Advanced Practice Clinical Experience in Oregon**

(Revised 10/01/2023)

**Instructions**

This form is to provide contact information and signatures of the designated preceptor and supervising faculty for each student completing clinicals in Oregon. If more than one preceptor will be involved in supervising the student, a separate form is required.

Electronic signatures or notations that signatures are on file with the nursing program are acceptable.

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| **PROGRAM INFORMATION** | | | | | | | |
| **Program / College / University Name** | | |  | | | | |
| **Student Name** | | |  | | | | |
| **Degree Sought**  **(MSN, DNP)** | | |  | | | | |
| **Student’s Specialty Track**  **(FNP, AGPCNP, WHNP, etc.)** | | |  | | | | |
| **CLINICAL EXPERIENCE – OREGON AGENCY or FACILITY** | | | | | | | |
| **Agency/Facility Name:** |  | | | | **Contact Person Name:** | |  |
| **Address (Street, City, State, Zip):** |  | | | | **Contact Person Position:** | |  |
| **Affiliation Agreement:** | **Yes** | **Date of Affiliation Agreement or other Clinical Site Contract:** | |  | | **Contact Person Phone#:** |  |
| **PROGRAM FACULTY or CONTRACTED CLINCIAL EVALUATOR**  **LICENSED IN OREGON & CONDUCTING ON-SITE VISITS** | | | | | | | |
| **Faculty Name:** |  | | | | **Faculty’s National Certification – APRN Role** | |  |
| **Faculty Oregon APRN License #:** |  | | | | **Faculty Contact Email:** | |  |
| **Faculty License Expiration**  **Date:** |  | | | | **Faculty Contact Phone#:** | |  |

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| **AFFIRMATION BY CLINICAL PRECEPTOR & SUPERVISING FACULTY** | | | | | |
| I,      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type or print name) agree to serve as **Clinical** **Preceptor** for the above-named student for the agreed upon time period. I will directly supervise this student and agree to provide comprehensive feedback regarding the competency of this individual to the above-named faculty. I understand that I must retain an unencumbered Oregon license for the duration of the time I serve as a Clinical Preceptor and will notify the program if I become the subject of a current Board investigation.  I meet the Oregon State Board of Nursing requirements as a preceptor, including:  Licensed practice a minimum of 2,080 hours;  Received clinical preceptor guidance from the program per OAR 851-051-0020(5)(g)(G); and  Hold a current, unencumbered Oregon license appropriate to the health professional area of  practice and congruent to the student’s specialty track.  Preceptor’s Oregon License Number:      \_\_\_\_\_\_\_\_ Expiration Date:  Specialty Area of Practice Congruent to Student’s Specialty Track:      \_\_\_\_\_\_\_\_  If an APRN, National Certifying Body      \_; Credential Awarded:      \_; Expiration Date: | | | | | |
|  |  | | |  | |
| **(Signature of Clinical Preceptor)** | | **Phone Number** | | | **Date** |
|  |  | | |  | |
| **(Signature of Program Faculty or Contracted Clinical Evaluator)** | **Phone Number** | | | **Date** | |
|  | | |  | |  |
|  |  | | |  | |
| **(Signature of Nursing Program Representative)** | | | **Phone Number** | | **Date** |