



Oregon State Board of Nursing
 17938 SW Upper Boones Ferry Road • Portland, Oregon 97224-7012
Phone: 971-673-0685 **License Verification:** 971-673-0679
Website: www.oregon.gov/OSBN

All forms must be submitted to OSBN by the educational institution.

CLINICAL PRECEPTOR AGREEMENT (revised 08/07/19) For Non-Oregon Based Programs Offering Advanced Practice Clinical Experience in Oregon

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.

PROGRAM INFORMATION			
Program / College / University Name:			
Student Name			
CLINICAL EXPERIENCE – OREGON AGENCY or FACILITY			
Agency/Facility Name:		Contact Person Name:	
Address (Street, City, State, Zip):		Contact Person Position:	
FACULTY PROVIDING ON-SITE CLINICAL EVALUATIONS IN OREGON			
Faculty Name:		Faculty Specialty (FNP, PNP-PC, etc.)	
Faculty Oregon APRN License #:		Faculty Contact Email:	
AFFIRMATION BY CLINICAL PRECEPTOR & SUPERVISING FACULTY			
<p>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. I meet the following Oregon State Board of Nursing requirements for a preceptor, including:</p> <ul style="list-style-type: none"> ○ Oregon licensure or certification appropriate to the health professional area of practice. License number: _____ Population Focus/Specialty Area: _____ (Examples: CNS; NP- FNP; NP-PNP-AC, etc.; DO-Family Medicine; MD-Internal Medicine, etc.) ○ Maintain student supervision appropriate to the accomplishment of learning objectives. 			
(Signature of Clinical Preceptor)	() -	Phone Number	Date
(Signature of Program Faculty Supervising Student)	() -	Phone Number	Date
(Signature of Nursing Program Representative)	() -	Phone Number	Date