You are required to seek out a preceptor and a potential site for your practicum experience. The DNP student is required to select a clinical preceptor, with a minimum of a master’s degree, outside of their current work setting. An exception may be in large organizations, for example, where the DNP student would be placed with a clinical preceptor outside the department or unit where they are employed. The preceptor must be willing and able to oversee your practicum experience in the location you choose appropriate to the role. Please include the name, title and credentials of the prospective preceptor when filling out this form.

Any changes, additions/deletion of clinical preceptors must be sent to Elaine by email at: vuoncinoe@wpunj.edu. Changes after the deadline may take an additional two months to complete the agreements and confirmation.

Upon receipt of this information, Elaine will forward to the DNP practicum faculty for approval of the clinical site/preceptor. Upon approval, a letter, agreement form, certification of documentation form, course outline and responsibilities in the preceptor partnership will be sent to the clinical preceptor and/or agency. (Until the signed agreement and completed certification of documentation form are returned to our office, students are NOT to start their clinical.) These agreements are considered as “contracts” between the WPUNJ and the clinical preceptor/agency. It is the responsibility of the student to follow this process. Call or email Elaine in the Graduate Nursing Office (973-720-3511 or vuoncinoe@wpunj.edu) as to whether the preceptor/agency has sent back their agreements and certification requirements.

In addition, it is the responsibility of students to show proof of compliance on the Nursing Clinical Documentation Checklist required for clinical placements every semester by the first day of the seminar/clinical. The documentation is to be submitted to the faculty teaching the course. Generally, the clinical preceptor/agency does not ask for documentation but at times, they have requested them. You are not permitted to start clinical without full compliance to the clinical requirements.

Upon completion of the course, you must submit to the faculty teaching the course all completed logs (with clinical hour verification), preceptor/site evaluations, and evaluation of personal learning objectives. You will not receive a grade in the course until the submission and course requirements are completed.

Please return PART II and III to the Department of Nursing Graduate Programs.
DNP PRACTICUM / PRECEPTOR INFORMATION SHEET

PLEASE SUBMIT PART II TO THE DEPARTMENT OF NURSING GRADUATE PROGRAM NO LATER THAN THE SUBMISSION DEADLINE DATE ON PAGE 1

Date Submitted: _____________     Semester:      ____Fall     ____Spring    ____Summer                   20____

Course Number (please √):       ____NUR 8350     ____NUR 8351    ____NUR 8360     ____NUR 8361

If any of the required fields are missing it will delay processing your paperwork and this form will be returned to you for completion

Student’s name _______________________________    Course #:  NUR ______________

Semester ___________________         cell phone# ________________________________

Preceptor Name & Credentials: __________________________________________________________

Population Focus (& specialty if applicable) Area of Practice ____________________________________________

Preceptor’s Facility ______________________________________________________________

Preceptor Business Address:

Street _____________________________________________________

City, State & Zip _____________________________________________________

Phone:             _________________________   FAX:________________________

EMAIL: _____________________________________________________

Preceptor’s Unit/Type of Site __________________________________________________________

(e.g., clinic, private practice, primary care setting, etc.)

Characteristics of Patients:

a) Gender ______________________

b) age (children, young adult, adult, elderly) __________________________________________

   c) ethnicity ______________________

Healthcare experience ____________________________________________

(e.g., primary care, chronic, in-hospital)
MUST BE COMPLETED BY PRECEPTOR:

a) Certification (specify type e.g. adult or family) _______________________

b) (specify certifying body e.g. ANCC or AANP) _______________________

c) (specify expiration date) _______________________

d) Years of practice in the population focused or specialty area: ________________

e) Number of students precepted concurrently: __________

f) State licensure # ___________________________ expiration date __________
   (REQUIRED) (REQUIRED)

g) Please attach a copy of your CV or Resume (REQUIRED)

Date of discussion regarding willingness to serve as preceptor: ________________________
Comments and/or description of proposed experience:

Clinical Preceptor Approval ________________________ Signature __________ Date __________

For Department of Nursing – Graduate Program use only. Do not write below double lines.

Director of Graduate Program or NP Faculty Approval:

____________________ Signature ___________________ Date __________

Comments: