

COLLEGE OF EDUCATION

WILLIAM PATERSON UNIVERSITY

School Nurse Clinical Experience

Instructions: Please type requested information within each cell. Once completed, print and return to the Office of Field Experiences no later than two weeks before the start of the semester.

First Name: _____ Last Name: _____ 855# _____

WP e-mail: _____ Home Phone: _____ Cell Phone: _____

Address (street and town) _____

Special Considerations in Placement

I will need WP to find a placement for my clinical experience.

I will complete my clinical experience in the school in which I work as a school nurse. (complete the information below)

School District _____

School Address (Street, City, State) _____

Semester and Year participating in clinical experience. _____

Attach the following to this application:

Current copy of NJ RN license

Current copy of CPR card (must have AED)

School Nurse Program Director: _____

Signature: _____ Date: _____

Comments/Notes: _____