



NURSING EXCELLENCE ★
Defining a New Era

**Children's National Medical Center
 Advanced Practice Provider Department**

**Nursing Academic Affiliations
 APN Preceptor Acceptance Letter**

STUDENTS: Once you have communicated with either a DNP/MSN/APRN or other qualified nursing professional, and he/she has agreed to precept you for the identified semester, please complete the following:

STUDENT NAME: _____

SCHOOL: _____

NAME OF FACULTY COORDINATOR: _____

PHONE: _____ **EMAIL:** _____

SEMESTER OF ROTATION:
 SPRING **SUMMER** **FALL** **YEAR: 20**_____

PRECEPTORS: Once you have agreed to precept an APN student, please complete the information below **AND RETURN TO STUDENT FOR INCLUSION IN THEIR APPLICATION PACKET.** Please email one copy to the school's faculty coordinator/contact.

NAME(S) OF PRECEPTOR(S) ACCEPTING STUDENT:

1. _____

2. _____

3. _____

CNMC DEPARTMENT: _____ **PHONE:** _____

PROPOSED DAYS/TIMES: _____

MAY THE STUDENT CONTACT YOU DIRECTLY TO SET UP SCHEDULES?
 By phone: **YES** **NO** By email: **YES** **NO**

I HAVE RECEIVED A COPY OF THE STUDENT'S COURSE OBJECTIVES
 YES **NO (STUDENT MUST PROVIDE A COPY BEFORE ROTATION BEGINS)**

 Student's Signature

 Date

 Preceptor's Signature

 Date

 Preceptor's Signature

 Date

Please email graduatenuingstudent@childrensnational.org or call 202 476- 4669.