

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 graduatenuisingstudent@childrensnational.org or call 202 476- 4669.