MENNONITE COLLEGE OF NURSING
ILLINOIS STATE UNIVERSITY

PRECEPTOR AGREEMENT FORM

Student Name: _________________________________________ Course Name & Number: __________________________
Starting Date for Clinical Experience: ______________________ End Date for Clinical Experience: __________________
Preceptor Name/Credentials: _______________________________________________________________________________
Practice Site: ______________________________________________________________________________________________
Address: ______________________________________________________________________________________________
______________________________________________________________________________________________
Phone (work): ____________________ Phone (home): ____________________ E-mail address: ____________________
Preceptor’s Approval Signature: _________________________________________________ Date: ____________________
Preceptor’s Supervisor (if applicable): _________________________________________________________________________
Address: ______________________________________________________________________________________________
Phone: ____________________
____________________________________________________________________________________________
Has the Preceptor previously precepted for Mennonite College of Nursing students?  Yes  No
If no, please complete this section.  If yes, then this section may be left blank.
1. ___________________________________________________________________________________________________
   Legal Name of Agency to Appear on Contract between MCN and Clinical Agency
2. _____________________________________________________________________  Phone: _______________________
   Name and Title of Contact Person for Contract between MCN and Clinical Agency
3. ___________________________________________________________________________________________________
   Name and Title of Person Legally Authorized to Sign Contract for Clinical Agency (if different than #2 above)
4. ___________________________________________________________________________________________________
   Phone Number and Clinical Agency of Person listed on Line #3 above (if different than #2 above)
5. ___________________________________________________________________________________________________
   Name of Person to whom the Clinical Agency Contract should be mailed (e.g., Office Manager, Administrative Assistant)
   Mailing Address, City, State, Zip Code

If you have questions or wish more information, please contact Mennonite College of Nursing at (309) 438-2176.
Revised 2/6/03