

Policy S-9  
FLORIDA STATE UNIVERSITY  
COLLEGE OF NURSING

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**TITLE: CLINICAL PRECEPTORS**

**POLICY:** The use of nurse preceptors in clinical nursing courses is consistent with the philosophy and guidelines of the FSU College of Nursing (CON) and the rules and regulations of the Florida Board of Nursing and the Florida Administrative Code.

**RATIONALE:** The faculty at the FSU College of Nursing believe that instruction by practicing registered professional nurses compliments the CON faculty and contributes a significant dimension to the learning experiences of students.

The Florida Administrative Code (FAC) 64B9-2.008 (13) (14) has specific requirements for the approval and use of preceptors in professional nursing undergraduate curriculum. These requirements include that a preceptor (1) have clinical expertise and competence in the area where serving as a preceptor; (2) be physically present in the unit and available to the student at all times; (3) be assigned no more than two students; (4) be provided with specific written objectives prior to the experience. The supervising faculty member must also be available to the student.

**PROCEDURE:**

Undergraduate Program:

1. Preceptors for undergraduate nursing courses must be licensed as a RN, preferably with a BSN degree, have at least one year of experience as a registered professional nurse (RN) and at least six months of experience in their current position.
2. Each preceptor shall be assigned no more than two (2) undergraduate students for any preceptor experience but a student may have multiple preceptors.
3. The FSU supervising faculty will provide an orientation packet to each preceptor prior to the beginning of the preceptorship that includes, but is not limited, to the following:
  - a. The names of students assigned to the preceptor
  - b. A list of clinical course objectives
  - c. A copy of the clinical evaluation tool to be used with CON faculty to evaluate the students' clinical performance
  - d. A list of preceptor role expectations for the course
  - e. Contact information for the assigned students and faculty

4. For the undergraduate course, NUR 4945, the faculty student ratio may be up to 1:18. Faculty must be available by telephone or email rather than on site.
5. For all other undergraduate courses using preceptors, the ratio may be up to 12 students and faculty must be on site and readily available.
6. Supervising faculty are responsible for (a) facilitating the written evaluation of student by preceptor and the placement of the evaluation in the students' academic file (b) evaluating the experience and the effectiveness of the preceptor and (c) assigning the final grade for the student.

### Graduate Program

1. The Assistant Dean of Graduate Programs will assist faculty and students in the identification of potential preceptors for graduate clinical experiences.
2. It is the responsibility of the preceptor to
  - a) meet the preceptor qualification criteria as defined by the FSU College of Nursing:
    - i. has a current, unencumbered Florida RN license.
    - ii. has at least three years of experience in the role.
    - iii. has been employed in the place of employment for at least one-year.
    - iv. has a graduate degree (e.g., MSN, DNP, MD, DO, PA) appropriate for assigned student learning activities (national certification preferred).
  - b) be willing to work with the student to facilitate learning.
  - c) be willing to participate with the student and faculty in evaluating student performance.
  - d) be supportive of the student/preceptor relationship.
3. Each preceptor shall be assigned no more than two (2) graduate students per semester; a student may have up to two preceptors per course.
4. Students are responsible for providing the Preceptor Approval Request Form (see Attachment #2) with the name, address, telephone, fax, and e-mail address of the preceptor to the Graduate Program Academic Advisor so that written affiliation letters can be completed and signed prior to students engaging in clinical experiences.
5. An orientation packet will be provided to each preceptor prior to the beginning of the preceptorship that includes, but is not limited, to the following:
  - a. The names of students assigned to the preceptor
  - b. A list of clinical course objectives
  - c. A copy of the clinical evaluation tool to be used with CON faculty to evaluate the students' clinical performance
  - d. A list of preceptor role expectations for the course
  - e. Contact information for the assigned students and faculty

- Supervising faculty are responsible for completing (a) the written evaluation of students using input from the preceptor and student, (b) the evaluation of the preceptorship experience, (c) the effectiveness of the preceptor, and (d) providing such information to the coordinator of the Assistant Dean of Graduate Programs for placement in the student's academic folder.

Approved by:

Faculty	6-16-06	12/1/06	8/11/10	6/25/15
Dean	6-21-06	12/5/06	8/11/10	6/25/15



**Attachment #1**

**Preceptor Approval Form - Graduate Program / FNP Track**

This form must be completed and signed by the student and the preceptor and returned to the Graduate Program Advisor at the FSU College of Nursing to obtain clearance to begin the clinical experience.

**Deadline for Submission: End of the 2<sup>nd</sup> week of the semester**

All information requested on this form must be provided and complete before submission.  
Fax your completed forms to **Fax # 850-645-7249**.

**I. Student Information** (Please print or type the following):

Student Name: \_\_\_\_\_

Instructor Name: \_\_\_\_\_

Semester/Year: \_\_\_\_\_

Course:  NGR 5003L  
 NGR 5064C  NGR 6601L  
 NGR6602L  NGR6619L  
 NGR6942L  NGR6943L

I understand that I **may not begin** clinical hours with this preceptor until I have received my Clinical Clearance **AND** my Preceptor Contract Request Form has been submitted and approved by the appropriate administrators in the College of Nursing. I understand that it is my responsibility to make sure that all required forms are on file and that I am cleared to begin my clinical experience. I also understand that if the facility where I intend to complete my clinical experience does not have an approved contract or affiliation agreement with the College of Nursing, then a Facility Contract Request Form must be submitted.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**II. Preceptor Information** (Please print or type the following):

Preceptor Full Name: \_\_\_\_\_  
 Include all credentials that apply (ARNP, RN, MSN, BSN, DNP, MD, DO, PA etc.)

Present Job/Title: \_\_\_\_\_ Length of Time in Current Role: \_\_\_\_\_

Health Care Provider License # & State of Issue: \_\_\_\_\_

Preceptor Phone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Facility Name: \_\_\_\_\_  
 (Include complete business/clinic name or indicate that it is a private practice)

Facility Mailing Address: \_\_\_\_\_  
 (Include Full Street Address, including Suite/Room Numbers)

\_\_\_\_\_  
 CITY STATE ZIP CODE

**Preceptor Educational Background** (please list all degrees conferred – add additional sheets, if necessary)

College or University Attended	Degree Earned (Bach, Master's, PhD)	Major Area of Study	Month/Year Degree Conferred

I certify that the information provided above is accurate and truthful to the best of my knowledge. I agree to precept the student identified above according to the guidelines provided to me in the course syllabus and confirmed by the course instructor.

\_\_\_\_\_  
Preceptor Signature

\_\_\_\_\_  
Date

Attach a list of all the preceptors you will be working with in the practice group.

**FNP Coordinator Approval**

Preceptor Criteria Verified:  Criteria Met  Criteria Not Met  
Clinical Clearance Docs Status:  Cleared  Not Cleared  
Current Contract on File:  Yes  Pending

Approved by: \_\_\_\_\_

Date of Approval: \_\_\_\_\_



# Preceptor Approval Form - Graduate Program/Nurse Educator and Nurse Leader Track

This form must be completed and signed by the student and the preceptor and returned to the Graduate Program Advisor at the FSU College of Nursing to obtain clearance to begin the clinical experience.

**Deadline for Submission: End of the 2<sup>nd</sup> week of the semester**

All information requested on this form must be provided and complete before submission. Fax your completed forms to Fax # 850-645-7249, or email it to [mschaldenbrand@fsu.edu](mailto:mschaldenbrand@fsu.edu)

**I. Student Information** (Please print or type the following):

Student Name: \_\_\_\_\_  
Instructor Name: \_\_\_\_\_  
Semester/Year: \_\_\_\_\_

Course:

- NGR 5714C     NGR 5718C
- NGR 5003C     NGR 5112C
- NGR 5772L     NGR 5773L
- NGR 5775L

I understand I **may not begin** clinical hours until I receive a signed preceptor approval letter from the College of Nursing. I understand that it is my responsibility to make sure that all required clinical documents are on file and that I am cleared to begin my clinical experience. I also understand that if the facility where I intend to complete my clinical experience does not have an approved contract or affiliation agreement with the College of Nursing and requires one, then a Facility Contract Request Form must be submitted.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**II. Preceptor Information** (Please print or type the following):

Preceptor Full Name: \_\_\_\_\_  
*Include all credentials that apply (ARNP, BSN, DN, MD, MSN, RN, etc.)*

Present Job/Title: \_\_\_\_\_ Length of Time in Current Role: \_\_\_\_\_

Health Care Provider License # & State of Issue: \_\_\_\_\_ Specialty: \_\_\_\_\_

Preceptor Phone number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Facility Name: \_\_\_\_\_  
(Include complete business/clinic name or indicate that it is a private practice)

Facility Mailing Address: \_\_\_\_\_  
*Full Street Address, including Suite/Room Numbers*

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

**Preceptor Educational Background** (please list all degrees conferred – add additional sheets, if necessary)

<i>College or University Attended</i>	<i>Degree Earned (Bach, Master's, PhD)</i>	<i>Major Area of Study</i>	<i>Month/Year Degree Conferred</i>

I certify that the information provided above is accurate and truthful to the best of my knowledge. I agree to precept the student identified above according to the guidelines provided to me in the course syllabus and confirmed by the course instructor.

\_\_\_\_\_  
Preceptor Signature

\_\_\_\_\_  
Date

**Attach a list of all the preceptors you will be working with in the practice group.**

**Nurse Educator Coordinator Approval**

Preceptor Criteria Verified:     Criteria Met     Criteria Not Met    Clinical Clearance Docs Status:     Cleared     Not Cleared  
Current Contract on File:     Yes     No     Pending

Approved by: \_\_\_\_\_

Date Approved: \_\_\_\_\_