St. Vincent's St. Clair
Nursing School Preceptorship Requests

Name of Nursing School: _____

Semester/Year: _____

Instructor Name: _____

Instructor Phone Office: _____

Instructor Phone Cell: _____

Instructor Email: _____

# of Clinical Hours required: _____

Preceptor Credentials required: _____

Dates of clinical (start/end): _____

Other requirements/special requests:

_____

_____

Student Name:	Top 3 Units requested:	Student Email:	Student phone #:

NOTE: Prior to first day of clinical experience the following required forms must be completed and turned in
for each student and Instructor:

1. **Schools of Nursing Student and Instructor Receipt Verification/General Orientation Manual Non Associates @ Clinical Affiliations.**
2. **HIPAA Privacy and Security Agreement & Acknowledgement.**
3. **St. Vincent's Health System and Affiliate's Corporate Responsibility and Ethical Practices.**
4. **Schools of Nursing Orientation Test**
5. **Student Information Form**

Email or fax to: Paula Leverton – paula.leverton@stvhs.com