Clinical Preceptor Professional Profile/Abbreviated CV

Information required of all Preceptors
LPN to RN Online Program Preceptors

This information is kept secured at the ACM Dept. of Nursing and remains confidential.

PLEASE PRINT

Student Last Name: _____ **Student First Name**_____

Preceptor: Last Name: _____ First Name:_____

Title: _____ Credentials:(BSN,MSN,etc.)_____ Practice/Clinical Site: _____

Institutional Affiliation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Work Phone #: _____ Work Fax #: _____

Clinical /Unit Director: _____ Director Phone Number:_____

HOME Address:_____ City: _____ State: _____

Zip:_____ Home Phone: _____

REQUIRED:**Emailaddress**_____

(Due to security purposes, no communications may be conducted via personal email)

Your Preferred Method of Contact:(check one) ☐ Work Phone ☐ Home Phone ☐ Email

Preferred Time of Contact:(check one)

DAY: ☐Mon. ☐Tues. ☐Wed. ☐Thurs. ☐Fri. ☐Any Weekday **Time:** _____

Licensure:

Type of License	License Number	State of Issue	Expiration Date

Preceptor Certification Information:

Type of Certification	Certifying Body	Years in Specialty Area	Expiration Date

Preceptor Last Name: _____ **First Name:** _____

Scholastic Background: (College, Professional, Graduate)

Institution	Dates Attended	Degree Earned

Work Experience:

Institution	Dates	Position

Professional Organizations/Associations:

Organization	Dates of Membership	Position Held

PRECEPTOR:

I have agreed to serve as preceptor for the above-named student enrolled at Allegany College of Maryland in the LPN-RN Online Program. I have signed the Clinical Preceptor Agreement Form. I am including this, my resume/Preceptor Profile for your records, as requested. I understand the information on this form will be kept confidential in the Department of Nursing.

Preceptor's Signature Date

_____

***Please FAX this form to ACM Nursing Department @ 301-784- 5106 Attn: LPN To RN Online Program or Email to** rnclinicals@allegany.edu