RADFORD UNIVERSITY
School of Nursing

Nurse Practitioner Clinical Practice Profile Form

This information is required to maintain program and university accreditation

*Date: _____

*Student Name: _____ Clinical Semester: _____ Course #:_____

*Preceptor's Name: _____ *Credentials_____

*Preceptor's E-Mail: _____ Telephone: _____

Preceptor's Specialty: _____ *Board Certified by: _____

*Name of Clinical Site: _____

*Address: _____

*City: _____ *State: _____ *Zip: _____

*Telephone: _____ Fax: _____ *Clinical Site's Main Contact: _____

*Clinical Site's Main Contact E-Mail: _____

*Practice Setting:
☐ Hospital Based
☐ Non-Hospital Based
☐ Rural Area
☐ Urban Area
☐ Psychiatry/Mental Health
☐ Primary care
☐ Non-primary care
☐ Telehealth
☐ Solo Practice
☐ Group Practice
☐ Other:_____

List Hospital Affiliations Below:
_____
_____
_____
_____
_____
_____

Number of eligible preceptors in the practice: _____

Has your preceptor rotated with other NP students before? ☐ YES ☐ NO

☐ NO ☐ YES Is your preceptor knowledgeable of the NP profession and role of the NP?

☐ NO ☐ YES Do they have previous experience as a preceptor for other NP Students?

☐ NO ☐ YES Will they provide orientation for you of the facility and discuss policies and regulations?

Number of Patients they see per week: (Please check one)

☐ 70-109 ☐ 110-129 ☐ 130-149 ☐ 150-179 ☐ 180-199 ☐ >200 ☐ Other: _____

On the first day of the rotation, student meets with?

Name/Title: _____ Date: _____

Location: _____ Time: _____

----Once Completed Upload to the D2L and email to Danielle Buonpane dbuonpane@radford.edu----