Preceptor Request

Complete a form for each clinical semester (fall, spring, summer). Include requests for different hospitals on the same form.

School Name: ______________________________ **Clinical Semester**: ______________________________

Primary Contact: Name: ____________________ **Phone**: ____________ **Email**: ______________________

Faculty Name: ________________________ Phone: ______________ **Email:** ______________________

Student Name	Hospital*	Unit Name / Type	First Day of Clinical Rotation	Last Day of Clinical Rotation	# Total Hours Per Student	Day(s) of Week	Shift or Hours	Preceptor Name and Contact Information For Office Use Only

*__EUH__: Emory University Hospital, **EUHM**: Emory University Hospital Midtown **EUOSH**: Emory University Orthopedic and Spine Hospital **WW**: Wesley Woods Geriatric Hospital **TEC**: The Emory Clinic **ESJH:** Emory Saint Joseph's Hospital

Send completed form to Susan Jones, Clinical Affiliations Coordinator, Nursing Education
Email: susan.jones@emoryhealthcare.org
Fax: 404-686-4905 Phone: 404-686- 2418

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