

**LOUISIANA STATE BOARD OF NURSING
5207 ESSEN LANE, SUITE 6
BATON ROUGE, LOUISIANA 70809**

PRECEPTOR QUALIFICATIONS FORM

Directions: Retain this form for each RN preceptor in the official records of the nursing program. This form shall be reviewed during the on-site survey of the nursing program by the Louisiana State Board of Nursing submitted upon request of the Board. License of the Preceptor must be visually inspected by the program head or his designee annually.

1. Name of Preceptor:

First Middle or Maiden Last

1.1 Social Security Number _____

1.2 Current Unencumbered LA RN License _____ Yes; _____ No

2. Employing Institution:

2.1 Name of Clinical Agency _____

2.2 Position or Job Title _____

2.3 Date of Employment _____

2.4 Major area of clinical practice _____

2.5 Length of time in Current Clinical Practice Area _____

3. Basic Nursing Education
(Indicate only one)

Institution

Date Earned

3.1 Diploma _____

3.2 Associate Degree _____

3.3 Baccalaureate _____

3.4 Generic Masters _____

4. Education Beyond Basic

Institution

Date Earned

4.1 Baccalaureate in Nursing _____

4.2 Masters in Nursing _____

4.3 Doctorate in Nursing _____

4.4 Doctorate in Other _____

5. Type of Preceptor: Indicate which of the following type of Preceptor is being Utilized

- _____ Senior Level Preceptor with a BSN and two (2) years of practices as a RN and one (1) year in the clinical area that the preceptorship experience occurs.

- _____ Community-Based Preceptor with BSN and two (2) years of practice as a RN with a minimum of one (1) year in the clinical area in which the experience occurs. An individual RN who does not possess a BSN must have at least three (3) years of experience as a RN with a minimum of one year in the clinical area in which the experience occurs.

6. Employment History: LAC 46:XLVII.3541.H and I. or 3542.G.6.

Clinical Practice: (List in chronological order. Start with the current year)

Employing Agency	Date of Employment	Full time	Part-time	Area of Responsibility

Signature of Preceptor

Name Printed

I certify that I have visually inspected the current Louisiana RN License for the above named individual.

Signature of Program Head or Designee

Date