State of New Hampshire

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION

DIVISION OF HEALTH PROFESSIONS

Board of Nursing

121 South Fruit Street, Suite 102Concord, N.H. 03301-2412

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NEW HAMPSHIRE PETITION FOR NON-NEW HAMPSHIRE BASED PRE-LICENSURE PROGRAMS OFFERING CLINICAL EXPERIENCE IN NEW HAMPSHIRE

Part B – Student Clinical Placement

If completing online, be sure to make a copy for your records.

INSTRUCTIONS: Complete Petition Part B for each student clinical placement. Page two may be duplicated for a student with multiple preceptors at the same agency/facility. (Non- New Hampshire based programs are required to submit Petition Part A annually.

ACTION REQUESTED

Action Type: New Submission Addendum/Revision of Previously Approved Clinical Placement	For Addendum/Revision of Previous Placement Only: Date Change — Date Extension Preceptor Change — Preceptor Addition Facility Change (same system) — Faculty Change

STUDENT INFORMATION

Student First Name (legal):		Middle Name or Initial:		Last Name:	
License Expiration Date:			Advisor's Name and Title:		
Student Phone:			Advisor's Phone:		
Student Email:			Advisor's Email:		

Official Use Only

License Verified:	Discipline Yes No	Date of Verification:	Initials:

PROGRAM INFORMATION

Student's Program /College/ University Name:	
Program City / State:	

Nursing Program Type:	Registered Nurse Practical Nurse

Student Name: _____

NEW HAMPSHIRE ASSIGNED PRECEPTOR					
Preceptor First Name (legal):		**Middle Name or Initial:**		**Last Name:**	
Preceptor New Hampshire RN License:	NA		**Preceptor Phone Number:**		
Preceptor New Hampshire/ Other License:			**Preceptor Certification(s) or Specialty:**		
Expiration Date:			**Preceptor Agreement Attached:**	**Yes** **No** **N/A**	
Official Use Only					
License Verified:	**Discipline** **Yes** **No**		**Date of Verification:**	**Initials:**	

NEW HAMPSHIRE ASSIGNED PRECEPTOR (If Additional Preceptor at same Location)					
Preceptor First Name (legal):		**Middle Name or Initial:**		**Last Name:**	
Preceptor New Hampshire RN License:	NA		**Preceptor Phone Number:**		
Preceptor New Hampshire/Other License:			**Preceptor Certification(s) or Specialty:**		
Expiration Date:			**Preceptor Agreement Attached:**	**Yes** **No** **N/A**	
Official Use Only					
License Verified:	**Discipline** **Yes** **No**		**Date of Verification:**	**Initials:**	

NEW HAMPSHIRE ASSIGNED PRECEPTOR (If Additional Preceptor at same Location)					
Preceptor First Name (legal):		**Middle Name or Initial:**		**Last Name:**	
Preceptor New Hampshire RN License:	NA		**Preceptor Phone Number:**		
Preceptor New Hampshire/ other License:			**Preceptor Certification(s) or Specialty:**		
Expiration Date:			**Preceptor Agreement Attached:**	**Yes** **No** **N/A**	
Official Use Only					
License Verified:	**Discipline** **Yes** **No**		**Date of Verification:**	**Initials:**	

Student Name: _____

CLINICAL EXPERIENCE – NEW HAMPSHIRE AGENCY or FACILITY					
Agency/Facility Name:				**Contact Name:**	
Street Address:				**Contact Position:**	
City:				**Contact Phone Number:**	
State / Zip:				**Contact Email Address:**	
Proposed Start Date:		**Projected Hours:**		**End Date:**	
Official Use Only				**Valid Site:**	**Initials:**

NEW HAMPSHIRE ASSIGNED FACULTY
IF APPLICABLE, ATTACH FACULTY APPROVAL FORM

Official Use Only			
License Verified:	**Discipline** Yes No	**Date of Approval:**	**Initials:**

IMPORTANT:

Form Review & Process Information

Form is completed appropriately and preceptor agreement(s) attached.

If Addendum/Revision, copy of the previously approved clinical placement letter or other acceptable document is attached.

- **Petition Status will be communicated to the program within three weeks of the date NHBON received completed petition.**
- **Students must contact their program directly for proof of required state approval before clinical starts. Failure to obtain approval is grounds for denial of clinical hours and civil penalty to preceptors/faculty.**

Official Use Only					
Date Received :		**Approved:**	**Yes No**	**Date of Approval* :**	
Comments:					
Signature:					
*** Proposed Start Date will be Clinical Start Date unless the approval occurs after the proposed date. In that case, the Clinical Start Date will default to the Date of Approval.**					
Approval Letter Sent:	**Date Sent:**	**Auto Verification Updated:**	**Yes No**	**Initials:**	