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

Telephone 603-271-2323 · Fax 603-271-6605

CLINICAL PRECEPTOR AGREEMENT
For Non-New Hampshire Based Pre-Licensure Programs Offering Clinical Experience in New Hampshire

Instructions:

This form is to provide contact information and signatures of the designated preceptor and supervising faculty for each student completing clinicals in New Hampshire. If more than one preceptor will be involved in supervising the student, a separate form is needed for each. The form(s) must be completed and attached to the Petition for Non-New Hampshire Based Programs Offering Clinical Experience in New Hampshire which must be submitted a minimum of three weeks prior to the start of the clinical experience. **All forms must be submitted to the NHBON by the educational institution. Email board.questions@oplc.nh.gov**

PROGRAM INFORMATION	
Program / College / University Name:	
Student Name	

CLINICAL EXPERIENCE – NEW HAMPSHIRE AGENCY or FACILITY			
Agency/Facility Name:		**Contact Person Name:**	
Address (Street, City, State, Zip):		**Contact Person Position:**	

ASSIGNED FACULTY- LICENSED IN NEW HAMPSHIRE IF APPLICABLE			
Faculty Name:		**Faculty Specialty:**	
Faculty NH License #		**Faculty Contact Email:**	

AFFIRMATION BY CLINICAL PRECEPTOR & SUPERVISING FACULTY

I,_____(insert name) agree to serve as **Clinical Preceptor** for the above named student for the agreed upon time period. I will directly supervise this student and agree to provide comprehensive feedback regarding the competency of this individual. I understand that I must retain an unencumbered New Hampshire license for the duration of the time I serve as a Clinical Preceptor. I meet the following New Hampshire State Board of Nursing requirements for a preceptor, including:

- New Hampshire licensure or certification appropriate to the health professional area of practice

AND

- Maintain student supervision appropriate to the accomplishment of learning objectives

Signature of Clinical Preceptor)	Phone Number	Date
Signature of Program Faculty Supervising Student)	Phone Number	Date
(Signature of Nursing Program Representative)	Phone Number	Date