



# PRECEPTOR AGREEMENT

Student Name:	_____	Date:	_____
Hospital Name:	_____	Fax:	_____
Hospital Address:	_____		
	<i>Street</i>		
	_____	_____	_____
	<i>City</i>	<i>State/Province</i>	<i>Zip/PC</i>

<b>Primary Preceptor</b>	_____	_____	_____	_____
	Last Name	First	MI	Title
	_____	_____	_____	_____
	Home Phone	E-mail Address	Signature	
	_____	_____	_____	_____
	Degree	Institution	Date of Award (Mo/Yr)	
	If an RVT or equivalent and not degreed, list state _____ and date of registration _____. You will need to fax in a copy of current licensure or diploma.			
<b>Additional Preceptor #2</b>	_____	_____	_____	_____
	Last Name	First	MI	Title
	_____	_____	_____	_____
	Home Phone	E-mail Address	Signature	
	_____	_____	_____	_____
	Degree	Institution	Date of Award (Mo/Yr)	
	If an RVT or equivalent and not degreed, list state _____ and date of registration _____. You will need to fax in a copy of current licensure or diploma.			
<b>Additional Preceptor #3</b>	_____	_____	_____	_____
	Last Name	First	MI	Title
	_____	_____	_____	_____
	Home Phone	E-mail Address	Signature	
	_____	_____	_____	_____
	Degree	Institution	Date of Award (Mo/Yr)	
	If an RVT or equivalent and not degreed, list state _____ and date of registration _____. You will need to fax in a copy of current licensure or diploma.			
<b>Additional Preceptor #4</b>	_____	_____	_____	_____
	Last Name	First	MI	Title
	_____	_____	_____	_____
	Home Phone	E-mail Address	Signature	
	_____	_____	_____	_____
	Degree	Institution	Date of Award (Mo/Yr)	
	If an RVT or equivalent and not degreed, list state _____ and date of registration _____. You will need to fax in a copy of current licensure or diploma.			