WELLSTAR

Office of Student Affiliations
PRECEPTOR CONFIRMATION
Please Submit One Form per Student

Date:_____ *Note: Requests should be made at least 15 business days before the start date.*

Student Name:_____

Program Name:_____ School Name:_____

Dates of Rotation: Start_____ End _____

WellStar Campus Location(s):

- ☐ WellStar Cobb
- ☐ WellStar Douglas
- ☐ WellStar Kennestone
- ☐ WellStar Paulding
- ☐ WellStar Windy Hill
- ☐ WellStar Medical Group

Will this student be dictating reports/consultations? (Nurse Practitioner & Physician Assistant Students Only)

☐ Yes ☐ No

Clinical Locations where Student will have patient contact/observation (i.e.: OR, Lab, etc.) *Please note: Unit managers may limit students' activities or entry to clinical areas.*

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Special clinical area badge access: (*Please note: This does **not** apply for observers.)*

- ☐ ICU
- ☐ ER
- ☐ OR
- ☐ Doctor's Lounge
- ☐ Sleep Room
- ☐ L&D
- ☐ Other _____
  _____

I understand and agree to accept responsibility for providing the necessary information to the Department of Student Affiliations to meet the requirements for processing this student.

I understand that WellStar Health System assumes no responsibility for the care of this student if injured while under my preceptorship.

I understand and agree to comply with WellStar's scope of practice outlined for students in this program.

I understand and agree to accept full responsibility for the proper conduct of this student, for observance of all Bylaws, Rules & Regulations and Policies of the Hospital(s) and Medical Staff(s), and for the correction and resolution of any problems that may arise during student's training rotation with me.

Preceptor Name:_____ E-mail:_____

Preceptor Signature: _____ License number:_____

Medical Practice or Group Name:_____

*Please return by **e-mail** to Carol.Westbrooks@WellStar.org or fax 770-937-4163*