DNP Practice Mentor Agreement

NGR 7494L

To be completed by DNP Student:

Student Name: _____ Semester: _____ Year: _____

Course Number/Title: _____ Hours Required: _____

Course Faculty: _____ Faculty Contact Number: _____

To be completed by Mentor *(please provide name as it appears on your professional license):*

Name: _____ Position/Title: _____

Degree (s): ☐ MSN ☐ DNP ☐ M.D. ☐ D.O. ☐ Other Degree (s): _____

Clinical Specialty: _____

Agency Affiliation: _____ Unit/Dept: _____

Practice Address: _____ **City:**_____ **State:** _____

Practice Site Phone Number: _____ Mentor Email: _____

I, _____ agree to act as a practice mentor for FGCU DNP student,
Preceptor Name
_____ to assist the student to achieve the required outcomes.
Student's Name

☐ I have been provided with a copy of the DNP Preceptor and Mentor Guidebook
☐ I understand and accept the responsibilities presented in the DNP Preceptor and Mentor Guidebook.
☐ I have been provided with an abbreviated course syllabus and understand the course objectives and practice requirements.
☐ I understand that if I have any questions, I should notify the faculty member designated above.
☐ I have attached a copy of my current resume/CV.
☐ I have attached a copy of my current License.
☐ I have attached a copy of my current certification.
☐ I understand this form, and my resume/CV, License, & Certification must be received by Program Director prior to student beginning DNP Practice Hours.

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Email ldownes@fgcu.edu or Fax (239) 590-7474 this completed form to Dr. Downes, DNP Program Director

Mentor Signature: _____ Date: _____

Student's Signature: _____ Date: _____

Internal Office Use
Mentor CV/Resume on File: ☐ Yes ☐ No Mentor License & Certification on File ☐ Yes ☐ No

Program Director Signature: _____ Date: _____