PROFESSIONAL NURSE SHORTAGE REDUCTION PROGRAM

PROFESSIONAL NURSING EXEMPTIONS
PRECEPTOR PROGRAM

Semester/Year Precepted:_____
Semester to Apply Exemption Credit:_____

This form must be completed in its entirety and returned to the Clinical Placement Coordinator (NUR 2.104U).

WARNING: Any person who knowingly makes a false statement or misrepresentation, fraudulently obtains an exemption under , or commits any other illegal action in connection with this program may be subject to a fine or imprisonment.

SECTION I

1. APPLICANT NAME
(Last) (First) (M.I.)

2. EID

N/A

3. CURRENT ADDRESS (Number, Street, Apartment Number, City, State, Zip Code)

4a. DAYTIME PHONE (Area Code/Number)

( )

4b. EVENING PHONE (Area Code/Number)

( )

5. EMAIL ADDRESS

6. EXEMPTION IS REQUESTED FOR

☐ **SELF** ☐ **CHILD/CHILDREN** ☐ **BOTH**

7. CHILDREN ENROLLED AT THE UNIVERSITY OF TEXAS AT AUSTIN

1. NAME _____ **DOB (MM/DD/YYY**_____ **EID** _____

2. NAME _____ **DOB (MM/DD/YYY)** _____ **EID** _____

3. NAME _____ **DOB (MM/DD/YYY)** _____ **EID** _____

4. NAME _____ **DOB (MM/DD/YYY)** _____ **EID** _____

5. NAME _____ **DOB (MM/DD/YYY)** _____ **EID** _____

SECTION II

8. ACKNOWLEDGEMENT

I, the above named applicant, have been informed of the requirements of this program. The above information is correct and complete, and I hereby authorize verification as required by the School.

Printed Name _____ Signature _____

Date _____

SECTION III (Verification-to be completed by School)

I certify that the above named applicant is under a current written preceptor agreement with the UT-Austin School of Nursing.

Name __Sheila Seals____ Title ___Assistant Director, Clinical & Compliance Services_____

Phone __512 471--8563_____ Fax ___512 232-4777_____

Signature _____