

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
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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/YYYY) _____	EID _____
2. NAME _____	DOB (MM/DD/YYYY) _____	EID _____
3. NAME _____	DOB (MM/DD/YYYY) _____	EID _____
4. NAME _____	DOB (MM/DD/YYYY) _____	EID _____
5. NAME _____	DOB (MM/DD/YYYY) _____	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 Carol Riazzi Title Clinical Placement Specialist

Phone 512 471--8563 Fax 512 232-4777

Signature _____