

**PROFESSIONAL NURSE SHORTAGE REDUCTION PROGRAM**  
**PROFESSIONAL NURSING EXEMPTIONS PRECEPTOR PROGRAM**

Semester Precepted: \_\_\_\_\_

Semester to Apply Exemption Credit: \_\_\_\_\_

This form must be completed in its entirety and returned to the Assistant Director, Clinical and Compliance Services (NUR 2.434).

**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**

<b>1. APPLICANT NAME</b> (Last) (First) (MI)	<b>2. EID</b>
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<b>3. CURRENT ADDRESS (Street Address, City, State, Zip Code)</b>	<b>4a. DAYTIME PHONE (Area Code/Number)</b>
	<b>4b. EVENING PHONE (Area Code/Number)</b>

**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 \_\_\_\_\_ Title Office of Student Services Staff Phone Number 512-232-4780

Signature \_\_\_\_\_