Faculty Clinical Course Details

**Clinical Course Title:**

**Faculty Contact Information:**

Name: Name: Name:

Primary Contact Number: Primary Contact Number: Primary Contact Number:

Email: Email: Email:

**Dates of Clinical Rotation:**

**Clinical Day(s) of the Week with student shifts Start/End Times:**

**Orientation Day Date:**

**Student Nursing Level** (circle): Freshmen Sophomore Junior Senior **Student Names:**

1.

**Clinical Course Objectives/Outcomes:** 2.

1. 3.

2. 4.

3. 5.

4. 6.

7.

**Skills Students Learning during Course/Expected to Perform in unit:** 8.

1. 9.

2. 10.

3.

4.

**Faculty Presence including minimal expectations and plan for check-ins with students:**

**Faculty Date(s) for shadowing bedside RN:**

**Plan for Student Attendance Changes:**

**Process for addressing concerns related to student preceptor, student learning experiences, challenging learning opportunities:**