Southern Union
State Community College

Health Sciences Division
1701 LaFayette Parkway
Opelika, AL 36801
Phone: (334)745-6437
Fax: (334) 745-6342

Site/Preceptor Agreement Form
Computed Tomography

Student Information

Name:_____ Email:_____

Phone: Home:_____ Work:_____

Clinical Site

Name:_____ Phone:_____

Address:_____

Preceptor

Name:_____ Email:_____

Phone:_____

I agree to serve as the preceptor for the student named above as he/she completes the Southern Union State Community College Computed Tomography Certificate Program. I have reviewed the course syllabus and the ARRT clinical activities (www.arrt.org). I understand and accept that my responsibilities as preceptor include, but are not limited to:

- Teaching and guiding the Computed Tomography student as he/she develops overall CT clinical skills
- Supervising and overseeing all CT student interactions with patients
- Teaching, evaluating, and documenting successful completion of the CT clinical competencies as identified in this syllabus
- Verifying the CT student's number of clinical contact hours
- Maintaining communication with the Southern Union State Community College faculty about the progress of the CT student in the program

_____ _____
Preceptor Signature Date

_____ _____
Printed Name ARRT #