



Southern Union State Community College

Health Sciences Division

1701 LaFayette Parkway
Opelika, AL 36801
Phone: (334)745-6437
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Site/Preceptor Agreement Form Magnetic Resonance Imaging

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

Preceptor signature

Date

Printed name

ARRT #