Candidate Information: (Completed by faculty coordinating the preceptorship)

1. The individual named above has completed ________ hours of preceptorship for

____

Name of the educational institution and program (e.g., University of xxx, School of Nursing)

2. The dates for the preceptorship were ______________________________ to ______________________________
3. This preceptorship was conducted with students in a

Nursing Program:

☐ Clinical Nurse Specialist (Master's or DNP)

☐ Nurse Practitioner (Master's or DNP)

☐ Nurse Midwifery (Master's or DNP)

☐ Nurse Anesthetist (Master's or DNP)

☐

Interprofessional Program:

☐ Medical

☐ Pharmacy

☐ Physician Assistant

Residency/Fellowship or Internship:

☐ Registered Nurse

☐ Nurse Practitioner

☐ Clinical Nurse Specialist

☐ Nurse Midwifery

Other nursing program (specify) ____

4. The specialty area or focus of this preceptorship was ____
5. The preceptorship was held in ____

Name of the hospital/institution/facility

____

Faculty coordinator name, credentials, and title (please print)

____

Educational institution

____

Program name

____

Institution address

____

Phone number

I hereby attest that the information provided on this form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in denial of certification or other adverse action.

____

Faculty signature Date

Note: