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:	Interprofessional Program:	Residency/Fellowship or Internship:
☐ Clinical Nurse Specialist (Master's or DNP)	☐ Medical	☐ Registered Nurse
☐ Nurse Practitioner (Master's or DNP)	☐ Pharmacy	☐ Nurse Practitioner
☐ Nurse Midwifery (Master's or DNP)	☐ Physician Assistant	☐ Clinical Nurse Specialist
☐ Nurse Anesthetist (Master's or DNP)		☐ Nurse Midwifery
☐ [redacted]		
☐		

☐ 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: