COLLEGE OF NURSING
UNIVERSITY OF UTAH

Verification of Preceptorship

Clinical teaching or precepting may be recognized by some certification organizations to meet a portion of your recertification requirements. This form documents the hours you served as a preceptor for that purpose.

Please *print* the following information:

STUDENT NAME: _____

PRECEPTORSHIP DATES: _____ (mm/yyyy) to _____ (mm/yyyy) TOTAL HOURS: _____

COURSE #: _____ SEMESTER: _____

PRECEPTOR NAME: _____

PRACTICE NAME: _____

PRACTICE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

PRECEPTOR'S SIGNATURE: _____
(acknowledging # of preceptor hours completed)

Thank you for your generous offering of time, energy and talent in the education of our students. Your efforts are a critical contribution to the knowledge and skills of our future health care professionals.

_____ _____
Sheila Deyette, PhD, APRN, PMHCNS-BC (date)

Program Director
Psych/Mental Health Specialty Track

10 S. 2000 E. · Salt Lake City, UT 84112 · phone: (801) 581-7728 · fax: (801) 581-4642