

## 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: \_\_\_\_\_ to \_\_\_\_\_ TOTAL HOURS: \_\_\_\_\_  
(mm/yyyy) (mm/yyyy)

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.*

\_\_\_\_\_  
Katie Ward, DNP, WHNP

\_\_\_\_\_  
(date)

Program Director  
Women's Health Specialty Track