



Preceptor Verification Form

To claim preceptorship hours for recertification, you must complete this form. The supervisor/coordinator or faculty member responsible for your preceptorship must verify the experience by signing this form. Category A vs B credit will be given based on the site of the preceptorship (clinical orthopaedics vs. non-orthopaedic nursing). Please print clearly.

First Name *MI* *Last Name*

The individual named above has completed at least 80 hours of nursing preceptorship.

The preceptor was in a clinical orthopaedic setting/general nursing setting (circle one) with a
 graduate student
 baccalaureate student
 associate/diploma student
 new employee

The dates (month/year) for the preceptorship were _____ to _____.

Name and address of the institution/facility in which preceptorship occurred:

Name

Street Address *City* *State* *Zip Code*

Name and address of the educational institution for which preceptorship occurred (if appropriate):

Name

Street Address *City* *State* *Zip Code*

My signature on this form affirms that the above-named certified orthopaedic nurse has completed at least 80 hours of preceptorship under my supervision.

Printed Name

Signature

Title

Telephone Number

Today's Date