BC-ADM Preceptor Form
Renewal Category #5

BC-ADM PRECEPTORSHIP FORM

Applicant Last Name _____ First Name _____Middle Initial _____

Certification Specialty_____

CANDIDATE INFORMATION
To be completed and signed by faculty coordinating the preceptorship

The individual named above has completed _____ hours of preceptorship for:

1. Name of the educational institution and program (e.g. University of X, School of Nursing, Pharmacy, etc.)

_____

2. The dates for the preceptorship were: _____ to _____

3. This preceptorship was conducted with students in:

Advanced Practice Programs: ☐Clinical Nurse Specialist program ☐Nurse Practitioner program ☐PharmD program

Undergraduate Program: ☐ Baccalaureate program ☐ Associates or diploma program

Residency/Fellowship: ☐ RN, NP or CNS residency or fellowship ☐ Pharmacist residency or fellowship

Other graduate program: (specify):

_____

4. The specialty area or focus of this preceptorship was:

_____

5. The preceptorship was held in: Name of the hospital/institution/facility, City, State:

_____

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

_____

Educational institution_____

Program name_____

Institution address_____

Telephone 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: *Please return this form to the candidate*