

CATEGORY E: PRECEPTING/CLINICAL EDUCATION VERIFICATION FORM E 5

Name:

Complete a Separate Form for Each Precepting Activity.

I Affirm that I have Served as a Preceptor For (which institution?):

Number of Students:

Type of Student:

Dates of Preceptorship (if Precepting for an Extended Period of Time, Indicate Date Range e.g. January – May 2018):

Total Hours:

Divided by 8 = Total AP Points:

Submit Letter of Support from Faculty Substantiating Preceptorship and Accomplishments (e.g. Hours, Projects, Evaluations) Including the Following Information:

- Faculty Coordinator
- Faculty's Institution
- Your name
- Hours of Preceptorship You Provided
- Area In Which You Provided Preceptorship (E.G. Nursing, Advanced Practice Nursing)
- Name of Educational Institution and Program (E.g. XX University, DNP Program)
- The dates for the Preceptorship
- Faculty Coordinator Name:
- Address:
- Phone:

AP POINTS CLAIMED FOR THIS ACTIVITY:

(Transfer this total to Point Log)