PRECEPTOR DOCUMENTATION FORM

Preceptor Name:	**School or Former work area:**
Preceptee:	**New work area:**

Preceptor Experience Objectives and Goals: (Answer: What will the learner be able to do after completing this experience?) List two or three SMART goals (Specific, Measureable, Achievable, Relevant, and Time Bound goals). A statement of a learning objective contains a verb (an action) and an object (usually a noun). See this site for assistance: http://www.celt.iastate.edu/teaching/effective-teaching-practices/revised-blooms-taxonomy

Date Worked	Hours Worked	Date Worked	Hours Worked

481-619.2(3) *j.* Participation as a preceptor for a nursing student or employee transitioning into a new clinical practice area, for a minimum of 60 hours as a part of an organized preceptorship program. A licensee shall maintain documentation issued by the institution supervising the student or employee demonstrating the objectives of the preceptorship and the hours completed. A preceptorship shall be recognized as 6 contact hours of continuing education.

As the supervisor of the above-named preceptor, I attest that the hours listed are true and accurate.

Name	**Title**
Facility Name	
Signature	**Date (mm/dd/yyyy)**