CERTIFICATION RENEWAL CATEGORY 5: PRECEPTORSHIP DOCUMENTATION FORM

Please do NOT submit this page with your renewal application. Keep this form with your records in case of audit.

INSTRUCTIONS

Renewal Category 5: Preceptorship

1. Complete a minimum of 120 hours as a preceptor in which you provided direct clinical supervision/teaching to students related to your certification in an academic program at the same practice level or higher.

2. Complete a minimum of 120 hours as a preceptor in which you provided clinical supervision/teaching related to your certification specialty in a formal fellowship, residency, or internship program at the same practice level or higher.

Keep this form with your records. You will need to submit it if you are selected for audit.

Social Security Number (optional) | Last Name | First Name
MI Certification Specialty

Candidate Information: (Completed by faculty coordinating the preceptorship)

1. The individual named above has completed _____ hours of preceptorship for

Name of the educational institution and program (e.g., University of xxx, School of Nursing)

2. The dates for the preceptorship were _____ to _____

3. This preceptorship was conducted with students in a

Nursing Program:

- ☐ Clinical Nurse Specialist (Master's or DNP)
- ☐ Nurse Practitioner (Master's or DNP)
- ☐ Nurse Midwifery (Master's or DNP)
- ☐ Nurse Anesthetist (Master's or DNP)
- ☐ Undergraduate Nursing (BSN, Associate, or Diploma)
- ☐ RN-BSN Programs

Interprofessional Program:

- ☐ Medical
- ☐ Pharmacy
- ☐ Physician Assistant

Residency/Fellowship or Internship:

- ☐ Registered Nurse
- ☐ Nurse Practitioner
- ☐ Clinical Nurse Specialist
- ☐ Nurse Midwifery
- ☐ Nurse Anesthetist
- ☐ Medical
- ☐ Pharmacy
- ☐ Physician Assistant

☐ Other nursing program (specify) _____

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

5. The preceptorship was held in _____
Name of the hospital/institution/facility

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

Educational institution

Program name

Institution address

Phone 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.