

## certification renewal category 5: Preceptorship Form

## **INSTRUCTIONS**

Complete a minimum of 120 hours of direct clinical supervision of nursing students in your certification specialty. CNSs and NPs must precept advanced practice nurses (CNS, NP, CNM, or CRNA) to fulfill this category. Please review the Certification Renewal Requirements at **www.nursecredentialing.org/RenewalRequirements.aspx** for descriptions of preceptor hours accepted. Keep this form with your records. You will need to submit it if you are selected for audit.

Return this form by mail to:

American Nurses Credentialing Center Attn: Certification Registration P.O. Box 8785 Silver Spring, MD 20907-8785

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

| Social Security Number (optional)  |                 |
|--|-----------------|
| Applicant Last Name First Name   | Middle Initial  |
| Certification Specialty  |                 |
| SECTION I: CANDIDATE INFORMATION Completed by faculty coor<br>1. The individual named above has completed hours of preceptorshi  |                 |
|  |                 |
| Name of the educational institution and program (e.g., University of xxx, Scho   | ool of Nursing) |
| 2. The dates for the preceptorship were:   | to              |
| <ul> <li>3. This preceptorship was conducted with students in a:</li> <li>APRN Programs: Undergraduate Nursing Program: <ul> <li>Clinical Nurse Specialist program</li> <li>Nurse Practitioner program</li> <li>Associates or diploma nursing program</li> </ul> </li> <li>Other graduate nursing program (specify):</li></ul> |                 |
| 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, an<br>providing false, inaccurate, or incomplete information may result in denial of c   |                 |
| Faculty signature  | Date            |

NOTE: Please return this form to the candidate.