AANPCP PRECEPTORSHIP FORM

Important Information:

- *Include this form with your Renewal of Certification application*
- *Name must exactly match legal identification used for AANPCP certification*
- **Preceptor Hours Conversion Table*** *may be found in the* **Certificant & Candidate Handbook**
- *Please Print Neatly*

Name: _____
First Middle Last

Month & Day of Birth (mm/dd): _____ Last 4 SSN: _____

AANPCP Certification # (begins with A, F, G, or AG): _____

Practice Site Name: _____

Address: _____

City, State, Zip: _____

Dates for this preceptorship were: From: _____ To: _____

Total # Preceptor Hours = _____ Conversion to Continuing Education Credits* -- > Total # CEs = _____

The Preceptorship was conducted with students enrolled in an:

APRN Program: ☐ Nurse Practitioner ☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Clinical Nurse Specialist

Interprofessional Educational (IPE) Program: ☐ Medicine ☐ Dentistry ☐ Pharmacy ☐ Other:

Specialty Area /Population Focus for this preceptorship: _____

Number of Students: _____

Faculty Coordinator Name & Credentials: _____

Faculty Coordinator Phone Number & Email address: _____

Educational Institution: _____

Educational Address: _____

Program Name: _____

ATTESTATION STATEMENT OF PRECEPTOR HOURS FOR RENEWAL OF CERTIFICATION

I have reviewed the policies regarding Recertification and Maintenance of Certification and understand my responsibilities and renewal options for AANPCP certification. I certify that all the information I have provided on this Preceptor Form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in my not being able to use preceptor hours for the renewal of my AANPCP certification. I understand that the information provided is subject to audit. Failure to respond to a request for further information could result in the expiration of my certification or other appropriate action as per AANPCP National Certification Board Policies and Procedures.

Signature: _____ **Date:** _____