

**GEORGIA BOARD OF NURSING
PRECEPTOR QUALIFICATION RECORD**

Name _____ Georgia License # _____
 Last First Maiden/Middle Cert. type & number # _____

Address _____ Cert. Exp. Date _____
 Street City State Zip Code

Work Phone _____ Home Phone _____ Email _____

Employed by _____
 Agency/Institution Address

Clinical Area of Expertise _____ Length of time in this agency _____
 (must be a minimum of one year)

List professional education/National certification in chronological order:

Name of Institution	Location	Diploma/Degree National Cert.	Year Granted	Major Field

Date of first licensure _____

Work History to develop this area of expertise.

POSITION	AGENCY/Location	DATES

Preceptorship:

Name of affiliating nursing education program Valdosta State University College of Nursing

Please describe how the student's learning goals are/will be enabled by your education and/or expertise:

My signature (preceptor) below indicates my willingness to serve as a preceptor for the following

courses: _____

I have received a copy of the preceptor responsibilities and the course objectives. I understand the faculty member will provide me with student name(s), telephone number(s) and dates of student clinical experiences in writing. The faculty will also provide me with telephone numbers of faculty involved in the above courses. The agency/designee signature indicates acknowledgment and approval of the preceptor position for this employee.

PRECEPTOR SIGNATURE

AGENCY/DESIGNEE SIGNATURE

DATE

DATE