## GEORGIA BOARD OF NURSING PRECEPTOR QUALIFICATION RECORD

Name				Georgia	License #
Last	First		Maiden/Middl	Le	
Address					
Stre	et		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 minimu	m of one year)
List professi	onal education/Nati	onal certific	cation in chro	onological order:	
			<u></u>	·····	

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

Date of first licensure

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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

SUBMIT FORM: