## Preceptor Form

For every 90 hours of preceptorship completed, 1 CEU will be awarded.

**To be completed by the preceptor:**

|  |  |
| --- | --- |
| **Name of Preceptor (receiving CPD credit):** |  |
| **Start Date of Preceptorship** |  |
| **End Date of Preceptorship** |  |
| **Training Institution** |  |

**List of Students Supervised:**

|  |  |  |
| --- | --- | --- |
| **First Name** | **Last Name** | **ID Number** |
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**To be completed by the supervisor:**

|  |  |
| --- | --- |
| **Supervisor Name** |  |
| **Supervisor Title** |  |
| **Supervisor Phone Number** |  |
| **Supervisor Email** |  |

I affirm that the above preceptor provided a minimum of 90 hours of formal, direct clinical supervision to the students listed above.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_