

PRECEPTORSHIP DOCUMENTATION

Preceptor Information:

Last Name	First Name	Social Security Number
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Confirmation Specialty _____

Completion by faculty coordinating the Preceptorship:

The individual named above has completed _____ hours of preceptorship for

University of South Carolina College of Nursing.

The dates for the preceptorship were: _____ to _____.

This preceptorship was conducted with students in a Family Nurse Practitioner program.

The specialty or focus of this preceptorship was _____.

The preceptorship was held at: _____
Facility Name

Faculty director name, credentials, and title: _____

Educational Institution: University of South Carolina

Program Name: College of Nursing Graduate Program (DNP/MSN/CGS)

Institution Address: 1601 Greene Street
Columbia, South Carolina 29208

Telephone Number: 803-777-2913

Signature: _____ Date: _____

My signature on the form attests to the fact that the information provided on this form is accurate.