ANCC
AMERICAN NURSES CREDENTIALING CENTER
CERTIFICATION

CERTIFICATION RENEWAL CATEGORY 5:

Preceptorship Form

INSTRUCTIONS

Complete a minimum of 120 hours of direct clinical supervision of nursing students in your certification specialty. CNSs and NPs must precept advanced practice nurses (CNS, NP, CNM, or CRNA) to fulfill this category. Please review the Certification Renewal Requirements at **www.nursecredentialing.org/RenewalRequirements.aspx** for descriptions of preceptor hours accepted. Keep this form with your records. You will need to submit it if you are selected for audit.

Return this form by mail to:

American Nurses Credentialing Center
Attn: Certification Registration
P.O. Box 8785
Silver Spring, MD 20907-8785

Please do not submit this page with your renewal application. Keep this form with your records in case of audit.

Social Security Number (optional)

Applicant Last Name | First Name | Middle Initial

Certification Specialty

SECTION I: CANDIDATE INFORMATION Completed by faculty coordinating the preceptorship.

1. The individual named above has completed _____ hours of preceptorship for:

University of Massachusetts Boston - CNHS - Nurse Practitioner Program

Name of the educational institution and program (e.g., University of xxx, School of Nursing)

2. The dates for the preceptorship were: _____ to _____

3. This preceptorship was conducted with students in a:

APRN Programs:
- ☐ Clinical Nurse Specialist program
- ☑ Nurse Practitioner program

Undergraduate Nursing Program:
- ☐ Baccalaureate nursing program
- ☐ Associates or diploma nursing program

Residency/Fellowship:
- ☐ RN residency or fellowship
- ☐ NP or CNS residency or fellowship

☐ Other graduate nursing program (specify): _____

4. The specialty area or focus of this preceptorship was: _____

5. The preceptorship was held in:

Name of the hospital/institution/facility, city, state

Faculty coordinator name, credentials, and title (please print)

Educational institution

University of Massachusetts Boston

Program name

Nurse Practitioner Program

Institution address

100 Morrissey Blvd., Boston, MA 02125

Telephone number

I hereby attest that the information provided on this form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in denial of certification or other adverse action.

Susan M. Lee, PhD, RN, CNP, ACHPN, FAAN Digitally signed by Susan M. Lee, PhD, RN, CNP, ACHPN, FAAN Date: 2019.11.10 07:40:41 -05'00' 11/10/2019

Faculty signature | Date

NOTE: Please return this form to the candidate.