

**PRECEPTOR/MENTOR VERIFICATION FORM**

*When reporting preceptor/mentor hours, this form must be submitted.*

**MSNCB National Office**

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Hours claimed are for providing clinical supervision to baccalaureate, masters or doctoral degree students and/or newly hired nurses in educational and professional settings.

*Courses taken about preceptorship or mentoring should be reported as CNE activities.*

30 hours as a preceptor/mentor = 5 CH, with a maximum of 20 CH per recertification period

This preceptorship must be verified by the signature of the faculty member or educator who supervised your preceptorship/mentorship.

*Please Print*

Preceptor's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

1. The individual named above has completed  hours of med-surg focused preceptorship/mentorship.

*Provide only the **number of hours worked** as a preceptor/mentor.*

2. The preceptorship/mentorship was with (Name of nurse): \_\_\_\_\_

Nursing Student

New Graduate Nurse

Newly Hired Nurse

3. The dates of preceptorship/mentorship were \_\_\_\_\_ through \_\_\_\_\_

4. Name of the facility/institution **OR** name of the educational institution for which preceptorship/mentorship

occurred: \_\_\_\_\_

**SUPERVISOR:**

I attest that the above named candidate has completed the number of preceptor/mentor hours indicated:

Print Supervisor Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

*An original signature is required for contact hours to be considered.*