

PRECEPTOR REGISTRATION FORM

INSTRUCTIONS

Practitioners : Please complete this form if you are currently registered as a preceptor with the CCNM Clinical Education (OCE) program. Please submit this form to the OCE office at least 5 business days in advance of your intended preceptorship. You will be contacted by the OCE with information regarding your registration and benefits.

Students: If you wish to participate in the health-care professional Preceptor Program, for preceptorship or for participation, please have the preceptor complete this form and return the submission to the OCE. The form must be submitted to the OCE at least 5 business days in advance of your intended preceptorship. You will be contacted only if there is a problem with your preceptor registration. Note that participation with a practitioner not registered with the Preceptorship Program will not be credited.

For more information on the CCNM Preceptorship Program please visit the Preceptor Program Information document (located online at <https://www.ccnm.edu/preceptor>)

This form must be completed by the practitioner. Please print legibly.

Student Number :

Address (): _____

Address : _____
Street | Unit | City | Province/State | Postal/Zip

Contact Information : _____
Phone # | Fax | E-Mail

What is the best time and method of contact? _____

Education, licensing and experience:

Health Care School Attended	Year Graduated	Degree Certification	Provincial/State License and number

Brief Description of Practice (including special focus areas):

Please indicate:

I wish to participate in the CCNM Preceptorship Program and be added to the list of eligible preceptors. %\ GRLQJ VR , XQGHUVWDQG WKDW , ZLOO DOORZ SURV S RIILFH IRU SUHFHSWRULQJ RSSRUWXQLWLHV \$V D &&10 SUHFHS &&10 VWXGHQW FOLQLFDO REVHUYDWLRQ LQ P\ SUDFWLFH RYHU WKH SURJUDP DW DQ\ WLPH DQG , ZLOO EH UHPRYHG IURP WKH

I wish to host a CCNM student for precepting this one time only. Do not add me to the CCNM Preceptorship Program list of practitioners. I understand that I may join the CCNM Preceptorship Program in the future and receive all the attendant benefits. This does not preclude students from contacting me or my office through resources other than the CCNM Preceptor Program.

Practitioner Signature: _____ Date Signed: _____

When this form is complete and is submitted to the Office of Clinical Education (OCE), it is considered approved within 5 business days unless you receive an e mail from the OCE stating otherwise.
****NOTE: Students will NOT receive credit for engaging in precepting with unapproved or non registered practitioners****

Submit form to the Office of Clinical Education by email or fax .
Email: oce@ccnm.edu
Fax: (416) 498-3158

<u>For Office Use Only:</u> Approved by:	Date:
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