Preceptor Verification Form
Advanced Practice Nursing Students
(Nurse Practitioner, Clinical Nurse Specialist & Nurse Midwife functioning in APRN role)

This form must be completed prior to the start of a clinical experience in any Prisma Health setting.

Student Information

Full Name: _____ School: _____

Phone: _____ Cell: _____

Email: _____

Nursing Faculty Contact Information

Full Name: _____ Phone: _____

Email: _____

Rotation Information

Dates of clinical experience: _____ _____

Start Date End Date

Prisma Health Facility/Department/Practice: _____

Preceptor Information

Full Name: _____

Phone: _____ Cell: _____

Email: _____

Verification of Responsibility for Advanced Practice Students

Verification of Collaborating Physician's Responsibility for Advanced Practice Students

This certificate shall acknowledge that I am licensed to practice medicine in the state of South Carolina and that I am aware of the standards of practice for advanced practice clinicals and scope of practice for nurses in South Carolina.

_____ _____ _____

Collaborating Physician Signature *Printed Name* *Date*

Verification of Advanced Practice Nurse Preceptor's Responsibility

This certificate shall acknowledge that I am licensed to practice nursing in the state of South Carolina, that I am aware of the standards of practice and any procedure specific protocols under which the advanced practice nursing student will be functioning pursuant to this affiliation agreement. I understand my responsibility to the APRN student and Prisma Health in utilizing these standards in the care of all patients.

I accept the above-named student for a clinical experience as an APRN nursing student.

_____ _____ _____

Advanced Practice Nurse Preceptor Signature *Printed Name* *Date*

Completed form is to be uploaded **by student** into myClinicalExchange: www.myclinicalexchange.com.