Washington State's Board of Nursing
NCQAC
Nursing Care Quality Assurance Commission

For use by Preceptor Program Only:

Place approval stamp here.

WA State Nurse Preceptorship Grant
Certification of Hours Form

Nursing Education Program please complete this section, sign, and give form to preceptor upon completion of the preceptorship:

1. Name of Nursing Program: Community College/Technical College ☑ University ☐ 123 Nursing Program
2. Faculty Responsible for Oversight of the Student Preceptorship: Jane Doe
3. Dean/Director Name: John Smith
4. Email: 123nursingpro@sample.net
5. Phone: 555-555-5555

6. Name of Preceptor:	Last Name: Clark	First Name: Sam
7. Term of Preceptorship:	Fall 2022 ☑ Winter 2023 ☐ Spring 2023 ☐ Summer 2023 ☐	

**If two students were precepted—please show a minimum of 80 hours for each student precepted to qualify for reimbursement AND provide student initials for reference. **Reimbursement is for precepting prelicensure students in the last term prior to graduation, and ARNP students in the first term of the first clinical experience of the nursing program.*

8. Student #1 Initials*: RR	Hours Precepted: 150	Start/End Date: 04/01/2023-04/12/2023
Type of student precepted: LPN ☐ ADN ☑ BSN ☐ ARNP ☐		

9. Student #2 Initials*:	Hours Precepted:	Start/End Date:
Type of student precepted: LPN ☐ ADN ☐ BSN ☐ ARNP ☐		

I attest that the above information, to the best of my knowledge, is correct and complete. I understand that the Nursing Commission may request more information, if needed, to evaluate the preceptor's eligibility. My signature confirms that the above-named preceptor has met the qualifying minimum of 80 hours per precepted student, which makes the preceptor eligible for the Preceptor Grant incentive.

Dean/Director Signature (*Required): /s/ John Smith (or) John Smith	Date: 04/13/2023

*****Preceptors,*** *the Dean or Director of the student's educational program must sign in this signature block. Please do not sign your name here. Instead place your signature in the signature block on page 3 of this form only.*

Once the COH form is complete, please send by email to **PGVerifications@doh.wa.gov**.

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Nursing Preceptor please complete this section:

If your contact information has changed and you have not updated your contact information with the Nursing Commission, please mark new on number 18-20 and we will get it updated.

10. Last Name: Clark	11. First Name: Sam	12. Birth Date: 8/8/19XX
13.Washington State Nurse License Number:	610555555	
14. Mailing Address: NEW ☐ 9876 N Street Apt #1	15. Email Address: NEW ☐ clarksam@example.net	
City, State, Zip Code: Olympia, WA 98501	16. Phone: NEW ☐ 545-525-5555	
17. Statewide Vendor Number (SWV) (*Required): SW-5555555-00	18. Last 4 Digits of Social Security Number: 5555	

***The Commission is unable to issue payments to preceptors without a SWV. Please apply with the Office of Financial Management (OFM) and get a SWV number prior to sending in the COH form.**

- To register for a SWV please visit the OFM website and register with Statewide Vendor/Payee Services. OFM will email you a vendor number in about 5-10 days.
- More information about completing the registration and a link to the registration form is available on the Preceptor Grant webpage.

19. Name of Facility Preceptorship occurred: Washington State Hospital

20. Type of Facility: Long-Term Care☐ Clinic☐ Acute Care☑ Community Setting/Other☐

21. WAC 246-840-533, defines a nursing preceptor as a practicing licensed nurse who provides personal instruction, training, and supervision to any nursing student, and meets specific requirements. Please check the box next to each item below to confirm that you meet the requirements as outlined in the WAC:

☑ I have an active, unencumbered nursing license at or above the level for which the student is preparing.

☑ I have at least one year of clinical or practice experience as a licensed nurse at or above the level for which the student is preparing.

☑ I was oriented to the written course and student learning objectives prior to beginning the preceptorship.

☑ I was oriented to the written role expectations of faculty, preceptor, and student prior to beginning the preceptorship.

☑ I am not a member of the student's immediate family, as defined in RCW 42.17A.005(27).

☑ I have no financial, business, or professional relationship that is in conflict with the proper discharge of the preceptor's duties to impartially supervise and evaluate the nurse.

22. Receiving a financial incentive was an important factor in becoming a student nurse preceptor:	1. Strongly Disagree☐ 2. Disagree☐ 3. Neutral☑ 4. Agree☐ 5. Strongly Agree☐

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Demographic Information:

23. Which category best describes your race/ethnicity?	☐ White ☐ Hispanic/Latinx ☐ Native American or Alaskan Native ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ Asian or Asian-American ☐ South/Central Asian or Asian-American ☐ Biracial or Multiracial ☐ Different Identity (please specify): _____ ☑ I prefer not to say

24. I attest that the included information, to the best of my knowledge, is correct and complete. I understand that the Nursing Commission may ask for more information, if needed, to evaluate my eligibility.	
Preceptor Signature: /s/ Sam Clark (or) *Sam Clark*	Date: 04/15/2023

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