

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 <input type="checkbox"/> University <input type="checkbox"/>
2. Faculty Responsible for Oversight of the Student Preceptorship:
3. Dean/Director Name:
4. Email:
5. Phone:

6. Name of Preceptor:	Last Name:	First Name:
7. Term of Preceptorship:	Fall 2022 <input type="checkbox"/> Winter 2023 <input type="checkbox"/> Spring 2023 <input type="checkbox"/> Summer 2023 <input type="checkbox"/>	

**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*:	Hours Precepted:	Start/End Date:
Type of student precepted: LPN <input type="checkbox"/> ADN <input type="checkbox"/> BSN <input type="checkbox"/> ARNP <input type="checkbox"/>		

9. Student #2 Initials*:	Hours Precepted:	Start/End Date:
Type of student precepted: LPN <input type="checkbox"/> ADN <input type="checkbox"/> BSN <input type="checkbox"/> ARNP <input type="checkbox"/>		

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):	Date:
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**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.

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:		11. First Name:		12. Birth Date:	
13. Washington State Nurse License Number:					
14. Mailing Address: NEW <input type="checkbox"/>			15. Email Address: NEW <input type="checkbox"/>		
City, State, Zip Code:			16. Phone: NEW <input type="checkbox"/>		
17. Statewide Vendor Number (SWV) (*Required):			18. Last 4 Digits of Social Security Number:		
<p>*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.</p> <ul style="list-style-type: none"> 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:					
20. Type of Facility		Long-Term Care <input type="checkbox"/> Clinic <input type="checkbox"/> Acute Care <input type="checkbox"/> Community Setting/Other <input type="checkbox"/>			
<p>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:</p> <p><input type="checkbox"/> I have an active, unencumbered nursing license at or above the level for which the student is preparing.</p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> I was oriented to the written course and student learning objectives prior to beginning the preceptorship.</p> <p><input type="checkbox"/> I was oriented to the written role expectations of faculty, preceptor, and student prior to beginning the preceptorship.</p> <p><input type="checkbox"/> I am not a member of the student's immediate family, as defined in RCW 42.17A.005(27).</p> <p><input type="checkbox"/> 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.</p>					
22. Receiving a financial incentive was an important factor in becoming a student nurse preceptor:			1. Strongly Disagree <input type="checkbox"/> 2. Disagree <input type="checkbox"/> 3. Neutral <input type="checkbox"/> 4. Agree <input type="checkbox"/> 5. Strongly Agree <input type="checkbox"/>		

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Demographic Information:

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

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