**Washington State Board of Nursing**

**CRNA Preceptor Verification of Hours Form**

**Gonzaga University**

**2024-2025**

**Preceptor Name (**Last, First Name):

|  |  |  |  |
| --- | --- | --- | --- |
| **Student Full Name**  **(Last, First)** | **Type of Clinical Settings** | **Date of Preceptorship Experience** | **Number of hours precepted** |
| Smith, John **(example)** | ER | 9/20/2024 | 5.5 |
| Shields, Brooke **(example)** | Surgery Center | 10/12/2024 | 12 |
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| **Total number of hours precepted:** |  |

**To be signed by the Program Director Gonzaga University Nurse Anesthesia Program only.**

I attest that the above information, to the best of my knowledge, is correct and complete. I understand that the Washington Board of Nursing 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.

/s/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(typewritten signatures are preferred)

**Please upload the completed form to the CRNA Preceptor Hours form via Survey Monkey listed on our website.**