Hawaiʻi Nursing Continuing Competency

Preceptor Activity Form for **NURSING EMPLOYEES**

LEARNING ACTIVITY OPTION**: 120 HOURS AS A PRECEPTOR FOR AT LEAST ONE (1) NURSING STUDENT OR EMPLOYEE TRANSITIONING INTO A NEW CLINICAL PRACTICE AREA.**

During the biennium, if you act as a preceptor for at least one nursing student or employee transitioning into new clinical practice areas for at least one hundred twenty (120) hours, in a one-to-one relationship as part of an organized preceptorship program; provided that the licensee may precept more than one student or employee during the one hundred twenty hours and shall be evidenced by documentation of hours completed and objectives of the preceptorship by the institution supervising the student or employee, this will satisfy as one of the learning activity options.
Precepting for orientation specific to employment (i.e. computer course, documentation, human resource policies or being oriented/precepted to a position) does NOT count. ***PLEASE COMPLETE ONE FORM PER ROTATION.***

PRECEPTOR INFORMATION

Preceptor Name:

License #:

EMPLOYEE INFORMATION

Employee Name:

Facility:

New Graduate: ☐ YES ☐NO	If NO, Former Specialty Area:
Current Specialty Area:	# of Precepted Hours:
Start Date:	End Date:

Preceptor Objectives:

Preceptor Attestation

I certify that all the information I have provided on this preceptor form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in my not being able to use preceptor hours to fulfill Continuing Competency requirements. I understand I must maintain my continuing competency records for at least four (4) years or two (2) biennium licensure cycles. I understand the information I have provided is subject to audit and the Hawaiʻi Board of Nursing reserves the right to request additional supporting documentation for validation of preceptorship experience. Failure to respond to a request for further information could result in the revocation of my nursing license or other appropriate action as per the Hawaiʻi Board of Nursing's policies and procedures.

Preceptor Name (PLEASE PRINT) :

Preceptor Signature: Date:

Facility Attestation

I certify that all the information provided on this preceptor form is true, accurate, and complete. I understand the information provided is subject to audit and the Hawaiʻi Board of Nursing reserves the right to request additional supporting documentation for validation of this preceptor experience.

Name (PLEASE PRINT) : Title:

Signature: Date:

This document is intended to standardize record keeping. It is the nurse's responsibility to ensure activities meet the requirements and documentation is complete and to follow document keeping standards as outlined by the Hawaiʻi Board of Nursing.

*Last updated 1/14/19