Nephrology Nursing Certification Commission

Preceptor Verification Form

CERTIFICATION/RECERTIFICATION (Circle designation): CNN / CDN

To be completed for a TOTAL of 8 Continuing Education Contact Hour Credits

SECTION 1: APPLICANT INFORMATION

You must complete ALL spaces in this section

NAME _____
Current Legal Last Name Legal First Name Middle Name

MAILING ADDRESS _____
Street Apt# City State Zip

LAST 4 DIGITS OF SOCIAL SECURITY NUMBER_____ E-MAIL _____

CELL/ HOME PHONE NUMBER _____ WORK NUMBER _____

SECTION 2: CONFIRMATION OF PRECEPTOR HOURS (To be completed by supervisor/precepting educator)

THE INDIVIDUAL NAMED ABOVE COMPLETED A TOTAL OF _____ HOURS OF PRECEPTORSHIP FOR:

FACILITY: _____ START DATE: _____ END DATE: _____

SUPERVISOR/PRECEPTING EDUCATOR NAME: _____

TITLE: _____ EMAIL: _____ PHONE: _____

SUPERVISOR/PRECEPTOR EDUCATOR SIGNATURE: _____ DATE: _____

SECTION 3: APPLICANT'S SIGNATURE/ATTESTATION

I hereby attest that the information provided on this form is true, accurate, and complete. I understand that providing false, inaccurate, or incomplete information may result in denial of certification or other adverse action. Furthermore, I understand the NNCC requirement is to have precepted for a **minimum of 160 hours or 4 weeks within the 3 years** prior to applying for certification or within the 3-year certification period for recertification.

APPLICANT SIGNATURE: _____ DATE: _____