CCNM
Canadian College of Naturopathic Medicine

PRECEPTOR REGISTRATION FORM

INSTRUCTIONS

Practitioners: Please complete this form if you are not currently registered as a preceptor with the Office of Clinical Education (OCE) or wish to update your information on file. Please submit this form to the OCE at least 5 business days in advance of student preceptoring. You will be contacted by the OCE with additional information about the preceptorship program and benefits.

Students: If you wish to register a health-care professional in the CCNM Preceptor Program, for a one-time preceptorship or for ongoing participation, please have the practitioner fill out the form and return it for submission to the OCE. The form must be submitted to the OCE at least 5 business days in advance of student preceptoring. You will be contacted *only* if there is a problem with the preceptor registration. ***Please note that preceptorship with a practitioner not registered with the CCNM Preceptorship Program will not be credited.***

For more information on the CCNM Preceptorship Program please see the Preceptor Program Information document (located online at https:www.ccnm.edu/alumni/preceptor)

Required fields to be completed by the practitioner. Please print legibly.

Date: _____

Student Name (If applicable):_____ **Student Number**: _____

Practitioner Name (First):_____ (Last): _____

Business Name (if applicable): _____

Address:_____|_____|_____|_____|_____
Street | Unit | City | Province/State | Postal/Zip

Contact Information:_____|_____|_____
Phone # | Fax | E-Mail

What is the best time and method of contact? _____

Education, licensing and experience:

Health Care School Attended	**Year Graduated**	**Degree Certification**	**Provincial/State License and number**

Brief Description of Practice (including special focus areas):

_____

_____

Number of Years Practicing _____

Number of patients seen in an average week_____**average day** _____

Please indicate:

☐ **I wish to participate in the CCNM Preceptorship Program and be added to the list of eligible preceptors.** By doing so I understand that I will allow prospective student preceptees to contact my office for preceptoring opportunities. As a CCNM preceptor, I will allow for at least 30 hours of CCNM student clinical observation in my practice over the course of one year. I may withdraw from the program at any time and I will be removed from the official preceptor list.

☐ **I wish to host a CCNM student for precepting <u>this one time only</u>. Do *not* add me to the CCNM Preceptorship Program list of practitioners.** I understand that I may join the CCNM Preceptorship Program in the future and receive all the attendant benefits. This does not preclude students from contacting me or my office through resources other than the CCNM Preceptor Program.

Practitioner Signature:_____ Date Signed: _____

When this form is complete and is submitted to the Office of Clinical Education (OCE), it is considered approved within 5 business days *<u>unless</u>* you receive an e mail from the OCE stating otherwise.

****NOTE: Students will NOT receive credit for engaging in precepting with unapproved or non registered practitioners****

Submit form to the Office of Clinical Education by email or fax.

Email: oce@ccnm.edu
Fax: (416) 498-3158

<u>For Office Use Only:</u>
Approved by: ***Date:***