Preceptor Academic & Professional Record

Office of Experiential Education

Full Name and Credentials: ______________________________ Date: ________________

Position or Title: ____

Name of Training Site: ______________________________ Phone number: ______________

Phone Number: ________________________ Email Address: ________________________

Please Select One:

Inpatient Outpatient Prescriber

Education:

College or University	Dates	Degree/Major

Professional Experience:

Practice Site	Location	Position & Title	Dates

***NOTE:** Please provide **only** the information requested. **DO NOT** submit any other materials (e.g., curriculum vitae or copies of publications) unless asked specifically to do so. Thank you.

Membership and Service in National, State, and Local Professional Associations:

Association	Member, Office Held, or Committee Served	Dates

Teaching Experience:

(e.g, precepting residents and/or pharmacy students, in-service lectures, presentations at professional meetings)

For Inpatient Preceptors:

Briefly describe your contributions/experiences in the following areas:

1. Improvements in and contributions to pharmacy practice: (e.g., developing, implementing new services.)

2. Appointments to drug policy and other committees of the organization (as applicable):

3. Recognition by peers as a model practitioner (e.g., board certification, fellow status):

3. Recognition by peers as a model practitioner (e.g., board certification, fellow status):

Title	Citation/Meeting (Journal, Organization)	Month/Year

5. Regular reviewer of the following (e.g., contributed papers or manuscripts submitted for publication):

6. Membership and Service in National, State, and Local Professional Associations

Association	Member, Office Held, or Committee Served	Dates

7. Teaching experience (e.g., precepting residents and/or pharmacy students, in service lectures, presentations at professional meetings):