|  |  |
| --- | --- |
| **NAME:**       | **CTFN No.:**       |
| **DATE:MONTH**:       | **YEAR:**       |

|  |
| --- |
| **Type, Date and Number of Days**(Preceptorship of Student or Diabetes Educator)      |
| **Program is diabetes related** [ ]  **yes** [ ]  **no** |
| **Describe the needs assessment of the student / new diabetes educator**      |
| **Describe the learning objectives of the student / new diabetes educator**      |
| **Describe the evaluation design**      |
| **What was your role in the preceptorship with the student/new educator?**        |

|  |
| --- |
| Student/New Diabetes Educator |
| Name:(print) | Signature | Date |
| **- And -** |
| Program Director/Manager |
| Name:(print) | Signature | Date |
| OR ANOTHER CDE MAY SIGN ONLY IF THE MANAGER/PROGRAM DIRECTOR IS UNAVAILABLE TO SIGN |
| CTFN No.: | Name: (print) | Signature | Date |