|  |  |  |
| --- | --- | --- |
| **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 |