Form 4B: Preceptorship of a Student or New Diabetes Educator

15 Credits for Each Type of Preceptorship Program.
Each type may only be counted once in a Credit Collection Period Issued: 2018

NAME: _____ **CTFN No.:** _____

DATE:MONTH: _____ **YEAR:** _____

NOTE: If you need more space for an entry attach a separate sheet with your name, CTFN No. and the additional information.

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?

New Diabetes Educator/ Student

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:

Portfolio Page: