**Form 4C: Preceptorship of a Student or New Diabetes Educator**

Credit Value: 10 Credits for Each Type of Preceptorship. Issued: 2019

**NAME:** Name. **CTFNno:** CTFNno.

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| **Type:**  **Start Date:** **Number of Days or Hours:** |
| **Describe the needs assessment** |
| **Describe the learning objectives of the student / new diabetes educator.** |
| **Describe the evaluation design.** |
| **What was your role in the preceptorship?** |
| **Please describe your new learning and relate to CDE® Competencies.** |

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| --- | --- | --- | --- | --- |
| New Diabetes Educator/Student | | | | |
| Name: (print) | | Signature: | | Date: |
| Program Director/Manager Name (print): | | Program Director/Manager Signature: | | Date: |
| Phone # | Email: | | CTFNno. (signing CDE® only): | |

Another CDE® may sign **only** if the Program Director/Manager is unavailable to sign. Signing CDE® must also indicate their CTFNno.