HOFSTRA NORTHWELL
SCHOOL of MEDICINE

Clinical Preceptorship Proposal Form 2016-2017

Hofstra Northwell School of Medicine
500 Hofstra University
Hempstead, NY 11549-5000

Student Name: _____ **MS:** ☐ 3 or ☐ 4 **Date:** _____

Mentor(s) Name: _____ **Mentor(s) Email:** _____

Mentor(s) Phone: _____ **Proposed Dates:** _____

Institution/School: _____ **Site:** _____

Title of Preceptorship: _____

Clinical Area of Interest:

Proposed Activities: *(please include supervisory structure and schedule)*:

Approved ❑ Not Approved ❑

Comments:

Proposed Learning Objectives: *(Identify at least three; please frame as knowledge, skills, and attitudes you hope to attain)*

By the end of this experience, I will (know/be able to/appreciate…)

1.)

2.)

3.)

How will you know if you have achieved these objectives?

Student Signature:_____ Date: _____

Mentor Signature:_____ Date: _____

Mentor Signature:_____ Date: _____

Approved ❑ Not Approved ❑

Comments: