



HOFSTRA NORTHWELL
SCHOOL of MEDICINE

Preceptorship Proposal Form 2016-2017

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

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

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

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

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

Title of Preceptorship: _____

Clinical or Non-Clinical: _____

Area of Interest:

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

Please use chart below if your Preceptorship is Clinical:

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					
Evening					

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:** _____

Office of Student Records Use Only

Approved

Not Approved

Date: _____

Comments: