



Oregon State Board of Nursing

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APRN Pharmacological Management Evaluation Form Part A

Applicant Name: _____
(Please print name)

Applicant Social Security Number: _____

Preceptor's Name: _____
(Please print name)

I agree to serve as a preceptor for the above named Advanced Practice Registered Nurse (APRN) applicant during her/his supervised practice component, and in this capacity, I will directly supervise and evaluate her/his competence.

1. I meet the following Oregon State Board of Nursing (OSBN) requirement for preceptors supervising prescriptive authority practicum :

- Current Oregon APRN with unencumbered Prescriptive Privileges (Clinical Nurse Specialist, Nurse Practitioner, or Certified Registered Nurse Anesthetist)

License Number: _____

- Current Oregon licensed Medical Doctor (DO / MD)

License Number: _____ Practice Specialty: _____

2. I do hereby affirm that the applicant will complete _____ hours of supervised practice at :

Facility / Program name: _____

Address: _____ City: _____ State: _____

Type of credit for Clinical Education Practicum:
CME Academic credit
CNE Other

Credit Granting Institution:

I understand that a site visit may be performed by the Oregon State Board of Nursing (OSBN) as indicated. I agree to contact the OSBN if there are significant safety or practice concerns during the supervised preceptorship.

Preceptor (Please print name) Address () Contact number

Date Preceptor's Signature