National Alliance of Wound Care and Ostomy™

WCC® Preceptor Application

ALL FIELDS MUST BE COMPLETED PRIOR TO CONSIDERATION (6/2019)

PRECEPTOR CONTACT INFORMATION

DO NOT ATTEMPT TO COMPLETE CLINICAL HOURS UNTIL PRECEPTOR HAS BEEN APPROVED. CONFIRM STATUS OF APPROVAL BY CALLING 877-922-6292

1. PRINT NAME (as it appears on your professional license)

Last: First: MI:

2. MAILING ADDRESS
Street:

City: State/Province: Country: Zip/Postal Code:

Mobile Phone
(   )

Email: (Required)

EDUCATION

4. PROFESSIONAL TITLE (List all that apply, LPN, RN, PT, etc)

License Type: _______________ License Number(s):__________________ State:___________

ORIGINAL Issue Date:_______________ Expiration Date: _______________

5. EDUCATION: (Diploma, BS, BSN, etc.)

____

____

WOUND CARE

7. PLACE OF EMPLOYMENT
(Hospital, LTC, LTAC, etc.)

____

____

8. OTHER BOARD CERTIFICATIONS: (CWS, CWOCN, CWCN, etc.)

****MUST PROVIDE A COPY OF CURRENT CERTIFICATION TO BE APPROVED****

Certification: ________ #: _________________ Date Issued: ___________

Certification: ________ #: _________________ Date Issued: ___________

9. LICENSED EXPERIENCE/PRACTICE WOUND CARE

☐ **Less Than 2 years** ☐ **2 to 5 years** ☐ **>5 but <10 years** ☐ **>10 years**

10. HOURS WORKED IN WOUND CARE PER WEEK:

☐ **Part Time - 8-20 hours** ☐ **Part Time - 21-39 hours** ☐ **Full Time - 40 or more**

10.PATIENT CASELOAD: Document the average **weekly** number of patients seen and type care setting.

Wound Type	Acute Care	Long Term Care	Home Health Care	Outpatient	Other
Pressure Ulcers					
Neuropathic (Diabetic) Ulcers					
Venous and/or Arterial					
Surgical					
Burns					
Trauma					
Palliative					
Dermatological					
Other Skin Problems					
TOTAL					

EMPLOYMENT

Complete the following sections to document required wound care related work experience. May attach additional pages if needed.

Current Employer____

Employer Address____

Employment Dates From:____/_ __/____to:____/____/____ ☐ Full Time ☐ Part Time

Supervisor Name:______________________________Supervisor Phone Number: ________________

Current Employer____

Employer Address____

Employment Dates From:____/_ __/____to:____/____/____ ☐ Full Time ☐ Part Time

Supervisor Name:______________________________Supervisor Phone Number: ________________

Current Employer____

Employer Address____

Employment Dates From:____/_ __/____to:____/____/____ ☐ Full Time ☐ Part Time

Supervisor Name:______________________________Supervisor Phone Number: ________________

ADDITIONAL QUALIFICATIONS

List any additional qualifications or clinical experience that may enhance your ability as a clinical preceptor.

AGREEMENT AUTHORIZATION

I hereby affirm that I have been a________________________actively and directly involved in the delivery of wound care for a minimum of
(Wound Certification Credential)
two years full-time within the past five years and a minimum of 1 year of experience since wound care certification.

I further affirm that I am currently licensed to practice as a__________________________in the state of____________________________.
(Professional License Type)
I further affirm that no licensing authority has current disciplinary action pending against my license to practice in the aforementioned or any other state, and that my license to practice is not currently suspended, restricted or revoked by any state or jurisdiction.

I authorize the National Alliance of Wound Care and Ostomy® to make whatever inquires and investigations that is deems necessary to verify my credentials and professional standing.

I have read and understand all the responsibilities of a WCC® Clinical preceptor, provided in attached NAWCO® preceptor handbook. I further agree to abide by the policies and procedures as set forth in the NAWCO® preceptor handbook and all conditions included in the NAWCO® preceptor agreement.

I declare that the foregoing statements are true.

______________________________________ ______________________________

Applicant signature Date