



Preceptor Clinical Timesheet

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|----------------------|------------------------|
| Student Name: | Preceptor Name: |
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| | | |
|---------------------------|--------------------|------------------|
| Clinical Location: | Start Date: | End Date: |
|---------------------------|--------------------|------------------|

Directions: Student is to track time in and time out every scheduled day during clinical preceptorship. Preceptor is to initial time sheet weekly to verify hours. Submit timesheet to National Alliance of Wound Care upon completion of clinical preceptorship.

| WEEK 1 | Date | Time In | Time Out | Total Hours |
|--------|------|---------|----------|-------------|
| Mon | | | | |
| Tues | | | | |
| Wed | | | | |
| Thurs | | | | |
| Fri | | | | |
| Sat | | | | |
| Sun | | | | |

| | |
|--------------------|--------------|
| Preceptor Intials: | Total Hours: |
|--------------------|--------------|

| WEEK 3 | Date | Time In | Time Out | Total Hours |
|--------|------|---------|----------|-------------|
| Mon | | | | |
| Tues | | | | |
| Wed | | | | |
| Thurs | | | | |
| Fri | | | | |
| Sat | | | | |
| Sun | | | | |

| | |
|--------------------|--------------|
| Preceptor Intials: | Total Hours: |
|--------------------|--------------|

| WEEK 2 | Date | Time In | Time Out | Total Hours |
|--------|------|---------|----------|-------------|
| Mon | | | | |
| Tues | | | | |
| Wed | | | | |
| Thurs | | | | |
| Fri | | | | |
| Sat | | | | |
| Sun | | | | |

| | |
|--------------------|--------------|
| Preceptor Intials: | Total Hours: |
|--------------------|--------------|

| WEEK 4 | Date | Time In | Time Out | Total Hours |
|--------|------|---------|----------|-------------|
| Mon | | | | |
| Tues | | | | |
| Wed | | | | |
| Thurs | | | | |
| Fri | | | | |
| Sat | | | | |
| Sun | | | | |

| | |
|--------------------|--------------|
| Preceptor Intials: | Total Hours: |
|--------------------|--------------|

| | |
|--|---------------------|
| For Verification Purposes - Please complete the following | |
| Name of Facility: _____ | DEPT: _____ |
| Name of Unit Manager: _____ | Phone: _____ |

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|--|--------------|
| I confirm that I have checked the timesheet and it is an accurate account of the hours worked by the student. | |
| PRECEPTOR SIGNATURE: | DATE: |

| | |
|---|--------------|
| I confirm this timesheet is an accurate account of my hours worked in the WCC Clinical preceptor rotation. | |
| STUDENT SIGNATURE: | DATE: |