

Preceptor Facility Verification Statement:

I, _____
(Preceptor Name)

practice in the _____
(Name & Address of Practice/ Clinical Group)

and operate under the

- Safety Standards,
- Clinical Facility Diagram,
- Restocking List,
- Oversight Form

for this facility. These updated master forms are on file with the National College of Midwifery.

Preceptor Signature: _____ Date: _____