

Preceptor Facility Verification Statement:

I, _____
(Preceptor Name)

Practice in the _____
(Name Practice/ Clinical Group)

Located at _____
(Address of Practice/ Clinical Group)

and operate under the

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

for this facility. I understand that it is my responsibility to keep these master forms on file with the National College of Midwifery, and to ensure that they are up to date.

Preceptor Signature: _____ Date: _____

This form should be used for preceptors who are using a facility for which NCM has an updated copy of these forms on file. Preceptors who are submitting their own copy of these forms do not need to use this.