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Preceptor Supervision Form:

Oversight

(Revised 10/06)

Date Completed:			
For YEAR:	*or*	Trimesters: Sep-Dec	Jan-May Jun-Aug Sep-Dec

Preceptor Name:	Student's Name:
Address:	City:
State: Zip Code:	Country:
Phone:	Fax:
Email:	

Oversight:

1. What is your learning plan for the Student to assure Associate Degree level work?
2. What student learning outcomes are you expecting?
3. How will you tailor your teaching approach to the student's learning style?
4. How will you address any obstacles or resistance your student may have to learning?
5. How will you maximize your student's special talents?
6. What formative (learning process) assessment tools will you use?
7. What summative (final evaluation, such as testing) assessment tools will you use?
8. Were there any Incident Reports? How were these resolved?
Oversight by: