# Document Verification Form 205a
# to be filled out by Preceptor

Applicant's Name: _____ Last four digits of Social Security #: _____

I, _____, a preceptor of

_____, (applicant's name) do hereby verify that they utilize in their practice the following documents:

- Practice Guidelines;
- Emergency Care Form;
- Informed Disclosure (given at initiation of care); and
- Informed Consent documents (used for shared decision making during care).

❑ **By checking this box, I affirm I was a NARM Registered Preceptor at the time of verifying the skill and/or clinical.**

_____

Print Preceptor's name

_____ _____

Preceptor's signature Date