Missouri State Board of Nursing
STATEMENT OF PRECEPTORIAL EXPERIENCE

I attest that ___________________________ has completed a minimum of 300
clock hours in the prescription of drugs, medicines and therapeutic devices.

__________________________  __________________________
Preceptor Signature        Preceptor Name (Please Print)

__________________________  __________________________
Preceptor Title            Date

__________________________  __________________________
License Number             State Issued

__________________________  __________________________
APRN Signature             Date

__________________________
APRN Name (Please Print)

STATEMENT OF PRACTICE IN APRN CATEGORY

I attest that ___________________________ has completed a minimum of 1000
hours of practice in an advanced practice nursing category, excluding the hours practiced
during their educational program.

__________________________  __________________________
Signature                  Date

__________________________  __________________________
Title                     Name (Please Print)

__________________________  __________________________
APRN Signature             Date

__________________________
APRN Name (Please Print)