

**Missouri State Board of Nursing**  
**STATEMENT OF PRECEPTORIAL EXPERIENCE**

I attest that \_\_\_\_\_ has completed a minimum of 300  
APRN Name (Please Print)  
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  
APRN Name (Please Print)  
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)