**Stony Brook University MS in Professional Nutrition Practice**

**Preceptor Commitment Form**

Thank you for committing to precept a student in the Stony Brook University MS in Professional Nutrition Practice. As a preceptor you will assist the student to select experiences that will meet assigned learning competencies. The learning objectives are available on the program’s website.

Please complete this form, sign and date it and return it to the student. If the student is accepted into the Stony Brook University MS in Professional Nutrition Practice, the program will reach out to you to facilitate getting a Clinical Affiliation Agreement executed.

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| --- | --- |
| **Preceptor Name:** |  |
| **Title:** |  |
| **Credentials:** |  |
| **Specialty:** |  |
| **Phone:** |  |
| **Email:** |  |
| **Facility Name:** |  |
| **Facility Address:** |  |
|  |
| **Years of experience in field/qualifications** |  |
|  |
| **Have you previously supervised students?** |  |
| **Rotation Type:**  **(check one)** | Advanced Nutrition Therapy  Food Service Systems & Management  Community Nutrition & Public Health |
| **Rotations Start/End Dates:** |  |

I have read the above and agree to serve as a preceptor for the following

Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preceptor Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*If precepting for the acute care portion of the Advanced Nutrition Therapy rotation, you will need to be employed by a Joint Commission Accredited (or other nationally recognized accrediting agency) facility and be an RD with at least 2 years of experience. For the Advanced Nutrition Therapy rotation in another setting such as Long Term Care, the RD credential is required with 2 years of experience in the field.*