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***FORM B1*: Documentation of Successful Completion of Pediatric Clinical Preceptorship**

Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Last First M.I.*

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Street City State Zip*

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[[1]](#footnote-1)

*Supervisor Certification*

* I certify that under my supervision, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name

 has completed her/his clinical preceptorship and has mastered

 competency in the following:

1. Forensic medical examinations (using simulation, if necessary) and;
2. Evidence collection using standardized sexual assault protocol and evidence kit and;
3. Pediatric patient assessment from all pediatric age categories covering growth and development, anatomy and physiology, head-to-toe examination, detailed genital inspection and;
4. Comprehensive care of pediatric sexual assault/abuse patients, including completion of sexual assault/abuse forensic medical examinations, sexual assault examination kits and psychosocial assessment.

 \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 Printed Name Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Title Hospital Affiliation

*Log of Precepted Exams*

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Location | Patient Age, Sex, Type of Exam | Preceptor Initials |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Please inform the SANE Program of any future changes of address [↑](#footnote-ref-1)