



Clinical Experience Preceptor (CEP) Agreement Form

Student: _____

Preceptor Information

Name: _____

Address: _____

Phone _____ **E-Mail** _____

Agency / Company _____

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1. I will plan the student's learning experiences that will include the major responsibilities of a Professional Geriatric Care Manager, including but not limited to participation in a comprehensive assessment and formation of a care plan, oral and written communication with caregivers, identification of appropriate social services and methods of evaluation of geriatric care services.

(Please Circle) Yes / No

2. I will allow the student to participate in 3 comprehensive assessments of geriatric care needs and the formation of plans to answer the needs.

(Please Circle) Yes / No

3. I will meet with the student on a regular basis during the clinical experience to monitor progress and address needs.

(Please Circle) Yes / No

4. I will provide written feedback to DOCE on the work of the student at the completion of the 50 hour clinical experience.

(Please Circle) Yes / No

CEP signature _____ **Date** _____

Please return all paperwork to:
Kenneth Nanni, Ph.D.
Division of Continuing Education,
The University of Florida
2209 NW 13th Street, Suite D
Gainesville, FL 32609
Fax# 352-392-6950