



**NORTH CAROLINA RESPIRATORY CARE BOARD**  
125 Edinburgh South Drive, Suite 100  
Cary, NC 27511

**Clinical Precepting Documentation**

**DIRECTIONS:** Please complete the form on page two for your clinical precepting records. A maximum of 3 credit hours are awarded per renewal year to satisfy the direct interaction requirements outlined in 21 NCAC 61.0401. This form must be kept in your CE file at work. You will be required to submit this document if audited.

**NCRCB POLICY:** Clinical Instructors/Preceptors must complete an Inter-Rater Reliability (IRR) training provided by the program, or another faculty approved program, to be eligible to receive Continuing Education (CE) credit for clinical instruction/precepting. IRR Training CE is only allowed credit once every other year per Board rules. IRR training completed with another RCP program or facility in NC is acceptable upon validation by the school. Completing a training course that includes the AARC Preceptor Course will provide 2 CEs from the American Association for Respiratory Care. If the school uses another Preceptor program in lieu of the AARC Preceptor Course, the school has the option to apply for CE with the NCRCB or AARC. Upon validation of direct clinical instruction/perception, the instructor may receive up to 3 hours of live CE credit from the NC Respiratory Care Board per 21 NCAC 61.0401.

Hours of clinical instruction/precepting will be validated based on student evaluations completed daily and credit hours are awarded as follows:

- 1 Hr. CE= 12 hours direct student contact
- 2 Hrs. CE= 24 hours direct student contact
- 3 Hrs. CE= 36 hours direct student contact

This policy is subject to change pending changes by the NC Respiratory Care Board.

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**SECTION A - PERSONAL INFORMATION**

RCP License Number: \_\_\_\_\_ License Renewal Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 (Last) (First) (Middle/Maiden)

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

\_\_\_\_\_  
 (City) (State/County) (Zip Code)

Telephone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

**SECTION B – College** *List the colleges that you engaged students in clinical precepting.*

Facility	Address	Phone Number	Dates

**SECTION C – AFFIDAVIT** (You must complete this section)

I, \_\_\_\_\_ certify that I am the person referred to in this documentation and that the statements herein are true and complete. I certify that I have read and understood the clinical precepting requirements for the contracted facilities listed above for \_\_\_\_\_ hours during the \_\_\_\_\_ school year and achieved an overall satisfactory rating.

\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 (Date Signed)

**SECTION D– FACILITY AFFIDAVIT** (The facility designee must complete this section)

I, \_\_\_\_\_ as the manager/supervisor/director/college faculty of respiratory care, certify that the facility has contacts with above colleges for RCP's to perform clinical precepting. I also certify that the RCP listed on this form has provided clinical precepting for the listed colleges and achieved an overall satisfactory rating.

\_\_\_\_\_  
 (Manager/Supervisor/Educator Signature)

\_\_\_\_\_  
 (Date Signed)