PRECEPTOR REPORTING FORM

Preceptor Name	
Mailing Address	
City	
State	
Zip	
Telephone Number	
Email Address	

By my signature below, I, a MSBO approved preceptor attest that the below stated optometrist was present for the required eight hours of preceptorship and , in so attesting, will offer no opinion, by implication or otherwise, that the optometrist is adequately trained or qualified to perform any patient care services with the YAG laser or any other equipment.

Optometrist Name Under Preceptorship _____

Date of Completion of the 8-Hour Requirement_____

Preceptor Signature: _____

Preceptor Name (Printed) _____