

**COMPETENCY TO PRACTICE INSTRUCTIONS**

You must demonstrate competency to practice by successfully completing refresher courses as defined in [Nursing Board Policy 10-03](#).

**If your licenses have been expired for two years or more and you have answered “YES” to the Licensing Information section question C on the Application for License by Endorsement, complete the following steps:**

1. Register for a Board-approved nursing education program / refresher course.
2. Within the guidelines of your chosen program / course, locate a qualified clinical agency (acute, subacute, skilled) to obtain the required, unpaid supervised clinical experience.
3. Submit a completed Non-Traditional Refresher/Remedial Program Instructor/Preceptor Agreement (attached) with your application.

**This process must be completed prior to the start of the clinical training.**

Upon review and approval of the application and Preceptor Agreement, your license will be issued in a Restricted Status, valid only for the purpose of completing the clinical experience.

4. Provide evidence of having completed all requirements as follows:
  - a. Obtain an official transcript or certificate in its official sealed envelope indicating completion of the Board-approved nursing education program or theory section of a refresher course;
  - b. Obtain a completed Non-Traditional Refresher/Remedial Program Skills Checklist from your Preceptor (attached) in an official sealed envelope.
  - c. Submit both documents in their unopened, sealed envelopes to the Office of Licensing.

Upon review and approval of both documents, the restriction will be removed from your license and a new license will be issued in an Active Status.

**NON-TRADITIONAL REFRESHER / REMEDIAL PROGRAM  
INSTRUCTOR / PRECEPTOR AGREEMENT**

*(All information requested in this form must be provided)*

\_\_\_\_\_  
Student name (print legibly)

\_\_\_\_\_  
Colorado License Number

This Agreement, by and between the Student, Instructor/Preceptor, Faculty\*, and Facility, is entered into for the purpose of providing clinical experience to Student pursuant to Colorado State Board of Nursing ("BON") Policy 10-03, which is incorporated herein by reference. See [www.dora.state.co.us/nursing/policies/policies.htm](http://www.dora.state.co.us/nursing/policies/policies.htm). For good and valuable consideration, the parties, whose information is fully set forth below, agree as follows:

**Instructor/Preceptor** agrees to provide (circle one): **(A)** clinical supervision in a traditional format with one instructor directly overseeing a small group of students –OR– **(B)** direct supervision of student on a 1:1 basis. Instructor/Preceptor agrees to evaluate Student's performance pursuant to the BON "Non-Traditional Refresher/Remedial Program Checklist" and to provide student with the required evaluation upon Student's completion of the clinical portion of the refresher/remedial course. In addition, Instructor/Preceptor will provide official transcripts and the Skills Checklist in a sealed envelope to student for submission to BON;

**Faculty\*** agrees that its non-traditional program will provide theoretical course work to Student as required by BON Policy 10-03;

**Facility** agrees that the clinical instruction required herein may be provided at its facility.

**Instructor/Preceptor:** \_\_\_\_\_  
Instructor/Preceptor signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_  
Title/Position: \_\_\_\_\_ Phone number: \_\_\_\_\_  
License No(s): RN \_\_\_\_\_ PN \_\_\_\_\_ Status of License(s): \_\_\_\_\_  
State(s) licensed: \_\_\_\_\_ Year(s) Issued: \_\_\_\_\_ Exp. date(s): \_\_\_\_\_  
Educational degrees: \_\_\_\_\_ Yrs. clinical experience: \_\_\_\_\_  
Schools attended & years graduated: \_\_\_\_\_

**Faculty:** \_\_\_\_\_  
Faculty member signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name of school: \_\_\_\_\_  
Address of school: \_\_\_\_\_  
Printed name of faculty member: \_\_\_\_\_  
Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**Facility:** \_\_\_\_\_  
Facility representative signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name of facility: \_\_\_\_\_  
Address of facility: \_\_\_\_\_  
Facility provides (circle all that apply): acute care subacute care nursing facility – PN only  
Printed name of facility representative: \_\_\_\_\_  
Title: \_\_\_\_\_ E-mail address: \_\_\_\_\_  
Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

**Student:** \_\_\_\_\_  
Student signature \_\_\_\_\_ Date \_\_\_\_\_

\* Faculty: Individuals meeting the requirements of the rules, designated by the governing body as having ongoing responsibility for curriculum development, planning, teaching, guiding, monitoring, and evaluating student learning in the classroom and practice setting.

**NON-TRADITIONAL REFRESHER / REMEDIAL PROGRAM  
Skills Checklist**

Student: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Program: \_\_\_\_\_

Faculty/Preceptor: \_\_\_\_\_

Clinical Supervision Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

> Please mark each competency as Pass or Fail <

Clinical Competencies	Pass	Fail	Preceptor Initials
<b>PN Provider Role</b>			
Performs services under the supervision of a registered nurse, physician, dentist or podiatrist.			
Performs and accurately collects basic health assessment data on patients contributing to the comprehensive patient assessment.			
Identifies common needs and problems, recognizes normal from abnormal findings and reports changes in findings to the appropriate health care professional.			
Contributes to the nursing plan of care.			
Provides basic care to those patients with predictable outcomes.			
Administers treatments, including medications as prescribed within the plan of care. Includes the medical plan of care and the nursing plan of care with: <ul style="list-style-type: none"> <li>• Has accurate knowledge of the treatment procedure, and expected outcome.</li> <li>• Skilled in safely administering the treatment.</li> <li>• Administers the right treatment to the right patient, at the right time.</li> </ul>			
Documents accurately and in a timely manner.			
Communicates to appropriate authority in a timely manner if patient refuses treatment, error is made, or an unpredicted event occurs.			
Uses technology, information and facility resources appropriately and effectively.			
Communicates in an accurate, clear and respectful manner with patients, families, supervisors and other Health Care Providers.			
Develops and maintains appropriate relationships with patients, families, colleagues, and other health care professionals.			
Participates in the evaluation of patient outcomes and implementing necessary change.			
Assists in the formation of a teaching plan based on the needs of the patient.			
Supports and reinforces teaching as prescribed in the plan of care.			
Reports changes in individual / family / group condition in a timely manner and to the appropriate supervisor.			

Clinical Competencies	Pass	Fail	Preceptor Initials
<b>PN Professional Role</b>			
Is current in knowledge of illness care and treatment trends.			
Promotes patient safety.			
Is a safe practitioner that practices within the PN scope of practice.			
Maintains patient confidentiality.			
Protects self and patients through safe practices such as universal precautions, lifting guidelines, and self-care practices.			
When directed coordinates, organizes and prioritizes care provided for the patient.			
<ul style="list-style-type: none"> <li>• Assigns care appropriately.</li> </ul>			
<ul style="list-style-type: none"> <li>• Monitors care provided by assignees.</li> </ul>			
<ul style="list-style-type: none"> <li>• Offers feedback to assignees on care provided.</li> </ul>			
<ul style="list-style-type: none"> <li>• Uses effective communication and conflict management skills.</li> </ul>			
<ul style="list-style-type: none"> <li>• Promotes teamwork.</li> </ul>			

I affirm that the clinical experience described on this form was conducted and completed in accordance with Colorado State Board of Nursing Policy 10-03. I further affirm that the clinical experience was completed under my supervision.

I declare under penalty of perjury in the second degree that the statements made herein are true and complete to the best of my knowledge.

Printed Name and Address of Preceptor: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Colorado License Number: \_\_\_\_\_

Preceptor Signature: \_\_\_\_\_  
Date Signed

Student Signature: \_\_\_\_\_  
Date Signed

*Instructor/Preceptor will provide the Skills Checklist in a sealed envelope to student for submission to BON.*