

**PRECEPTOR APPLICATION** *PLEASE TYPE OR PRINT CLEARLY*

|  |
| --- |
| **Section I** |

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

**Preceptor Name:** (Last) (First) (Middle) (Suffix: Jr, Sr, III, etc) (Degree: MD, DO, PA-C, NP, etc.)

**\*\*\*If PA-C, collaborating physician’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (B3.03A-E B3.06B)**

**Facility/Practice Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preceptor Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daytime Phone Number:\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Manager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preceptor / Office Manager E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

◻ I have included a copy of my C.V., state licensure, & board certification with this letter.

◻ I will e-mail a copy of my C.V., state licensure, & board certification at a later time.

|  |
| --- |
| **Section II** |

**Practice Type: (Please check all that apply)**

❑ **Hospital Clinic (HC)** ❑ **Non-Profit Health Clinic (NPHC)**

❑ **Private Group Practice (PGP)** ❑ **Public Health Clinic (PHC)**

❑ **Rural Health Clinic (RHC)** ❑ **Private/Solo Practice (PSP)**

❑ **Community Health Clinic (CHC)** ❑ **Military (MIL)**

❑ **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Practice Specialty: (Please check all that apply)**

❑ **Family Practice** ❑ **Surgery** ❑ **Women’s Health** ❑ **Internal Medicine** ❑ **Pediatrics** ❑ **Emergency Medicine** ❑ **Behavioral Medicine** ❑ **Orthopedics** ❑ **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section III**

Student Scheduling:

The SNU PA Program Supervised Clinical Preceptorships occur roughly consistent with the calendar months. Please indicate which months you are available to precept and how many students for that particular month, or simply indicate a number of students that you are interested in precepting each calendar year.

#\_\_\_\_Jan #\_\_\_\_Feb #\_\_\_\_Mar #\_\_\_\_Apr #\_\_\_\_May #\_\_\_\_Jun #\_\_\_\_Jul

#\_\_\_\_Aug #\_\_\_\_Sep #\_\_\_\_Oct #\_\_\_\_Nov #\_\_\_\_Dec

or total number of students per year \_\_\_\_\_\_\_\_

****