CARROLL UNIVERSITY

Please return to:
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Carroll University Physician Assistant Program
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PRECEPTOR INFORMATION:

Name_____ Title_____

Organization or Facility Name_____

Phone_____ Fax_____ E-Mail_____

Address_____

City_____State_____ZIP_____Population_____

Preceptor Specialty: _____ Board Certified: Y/N Years in Practice_____

Current License #:_____ State: _____ Any restrictions? ____Yes ____No

Hospital Affiliations:

_____#beds_____

_____#beds_____

_____#beds_____

Have you trained PA, NP, or Medical students in the past? ____ Yes ____ No

List the names of other providers who may be responsible for part of the student's training: (Please print. Use other side if more lines are required)
Name - Title (PA, MD, DO, NP, CNM, etc.) *License #* *Restrictive(Y/N)*

1._____

2._____

3._____

Person(s) other than yourself to contact regarding rotation scheduling, approvals or confirmation:

Name_____Phone/Email:_____

Name_____Phone/Email:_____

Name_____Phone/Email:_____

ADDITIONAL INFORMATION:

1. Can the site provide housing? _____Yes _____No

2. What type(s) of setting(s) would the student be exposed to? (Check all that apply)
   ____ Outpatient ____ Inpatient ____ Long term Care ___ Emergency

3. What are your normal working hours: (M-F, 8-5, call weekend, occ evening)
   _____

4. What is the approximate patient load per day? _____

5. Would you consider the majority of your patients "medically underserved"? Yes No
   Comments:_____

   _____

   _____

6. Are you a ____ profit or ____ non-profit facility?

7. Are the patients and your staff aware of the PA concept? YES NO
   If no, do you want assistance in introducing the concept? YES NO

8. Would the student be permitted to see patients in the hospital? YES NO

9. Do you foresee specific limitations on what the student can do? YES NO
   (Other than those placed on all students). If so, what: _____

_____

_____

10. Do you have any specific student preferences that could affect student assignment to your preceptorship?_____

_____

11. Other Comments: _____

_____

_____

Preceptor Signature_____Date_____