Preceptor Qualification Form

The purpose of this form is to qualify licensed health professionals as preceptors for the Mount St. Joseph University Physician Assistant Program

Preceptor Name: ____

Clinic Name: ____

Preceptor Specialty: _____________________ Board Certified: Yes No Eligible DOB*:___________
*Please provide Date of Birth since DOB is required to run board certification on some Board websites.

Preceptor Degree: MD, PA, DO, NP, CNM, PhD, LCSW, other _______ License #_____________

If PA, NP, CNM, PhD, LCSW, or other, please provide Supervising/Collaborating Physician's Name:
____ DOB*:_______________
Supervising/Collaborating Physician Board Certified: Yes No Eligible
*Please provide Date of Birth since DOB is required to run board certification on some Board websites.

Office Contact Name: ___________________________Office Phone: _____________________________

Office Address: ____

Office Fax: ________________________ Email of preceptor: ___________________________________

Question to be addressed with preceptor/site:
What is your routine office schedule? (For example M-Fri 8-5, Mon-Fri 8-5 off Wed pm…)?

What is your routine hospital schedule (for example: round every AM and PRN…)

Is there another provider who will be providing coverage on days you are off? If so, what is their name and credentials?

What is the average number of patients seen by the Preceptor in one day? _________

Will the student be allowed to take a history & perform an exam on the patient? Yes or No

Will the student be allowed to document in the medical record and fill out prescriptions? Yes or No

Will the student be allowed to observe AND participate or perform clinical procedures? Yes or No

Will the student be afforded the same space and privileges as the staff in terms of parking, restrooms, lockers, changing area, personal safety, and etcetera? Yes or No

Types of patients the student will see: check all that apply:

	Pediatric		Outpatient		Post-operative
	Adult		Inpatient		Pre-operative
	Geriatric		Nursing Home		Walk-Ins
	OB/Gyn		Emergency Dept		Returning/Follow-up
	Prenatal/Perinatal		Intra-operative		New Patients

Setting: Check all that apply:

	Private Practice		Inner City		Rural
	Hospital Based		Government		Health Manpower shortage area
	Group Practice		HMO		Other

Check all that apply:

	I have precepted medical students before
	I have precepted Physician Assistant students before
	I currently practice with a Physician Assistant
	I have practiced with a Physician Assistant in the past
	I am interested in employing a Physician Assistant in the future

Educational Approach: Check all that apply:

	Student receives feedback after each pt.		Student documents findings in the medical record.
	Daily performance feedback.		Student participates in procedures.
	Student only observes.		Student gives presentation on topics.
	Student evaluates patients prior to		Student expected to do daily oral case presentations.
	Student presents findings to preceptor.		Students will actively participate in surgical procedures
	Student participates in hospital rounds.		Other:

Types of educational events/materials: Check all that apply:

	Student receives lectures
	Student attends conferences.
	Student is given specific assignments (reading/research/DVD-CD/video/audio) topics.
	Student is questioned related to assignments
	Student presents findings of assignments to preceptor.
	Student is required to use/have specific books/workbooks
	Other:

Miscellaneous:

	I am interested in being contacted about the possibility of giving a medical lecture at the PA program
	Topics or subject areas:
	I am interested in teaching a course during the didactic phase of PA training

Observations/Comments/Suggestions (i.e., physical environment/facility/resources/ interpersonal environment):

How many students can the training site accommodate during one rotation: _______

How many per year: _______

List Hospital/Surgery Center/Clinic Affiliations:

1)

2)

Signature of Faculty Member Completing Form: ____

PA Program will complete the remainder of document. Please do not write below this line:

Original Date of Evaluation: _________________

Review Date: ____________________ Faculty Signature: ___________________________

Review Date: ____________________ Faculty Signature: ___________________________

Review Date: ____________________ Faculty Signature: ___________________________

Clinical Committee review:
Date: __________ Clinical Director: ____________________________

Date: __________ Medical Director: ____________________________

	The preceptor was or has been provided a copy of the preceptor handbook and rotation syllabus
	This training site meets the minimum above stated criteria.
	This training site does not meet the minimum above stated criteria.

Preceptor License #/State: ________________________________ License verified unrestricted: YES/NO

Preceptor Board Certified in: _________________ Certification verification source: ___________________
Board Eligible: YES/NO Experience and Qualifications are reflected in attached CV. Notes:

Supervising/Collaborating Physician's License #/State: _____________ License verified unrestricted: YES/NO

Supervising/Collaborating Physician Board Certified in: ____
Certification verification source: ____
Board Eligible: YES/NO Experience and Qualifications are reflected in attached CV. Notes: