

Preceptor & Site Profile Form 2024-2025

Preceptor Information (MD, DO, PA, NP, LPC, MSW, etc.)

Name and Credentials				
Are you Board Certified?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Board Eligible
Area of Board Certification				
National Certifying Board				
Date certified/re-certified (Mo/Yr)				
Practice Specialty				
Medical License	Number:	State:	Expiration Date:	
Email address				
Preferred contact phone (for program use only)		<input type="checkbox"/> cell <input type="checkbox"/> office <input type="checkbox"/> pager <input type="checkbox"/> home		
Phone no. <i>students</i> may use to contact you.		<input type="checkbox"/> cell <input type="checkbox"/> office <input type="checkbox"/> pager <input type="checkbox"/> home		
<i>If a PA, please provide the name of your primary supervising physician and his/her medical license number.</i>				

Practice Contact Information

Practice/Group Name: (Contract Entity Name) Please Attach Certificate of Insurance			
Employer Name (if different from above):		<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Employed by
Main Office Address:			
Rotation Address: (If different from above)			
Contact Person/Office Manager: <i>*For rotation scheduling.</i>	Name:		
	Phone:		
	Fax:		Email:

Clinical Exposure *Appropriate breadth and depth of exposure on clinical rotations is supported by sufficient hours, adequate patient volume, and active hands on participation.*

- Please indicate the number of hours/week in each setting, that the student will be seeing patients.
Outpatient _____ Inpatient _____ OR/Surgery _____ ED _____ Other _____
- Can the Provider guarantee an average of 36 clinical hours/week for the duration of the rotation period? Y N
If NO, are there other Providers within the group/practice willing to precept the student in your absence? Y N
- Approximately how many patients do you see daily? (Includes outpatient, inpatient, OR, ED, etc.) _____
- Please select the activities that students will be allowed to observe/perform with supervision, during their time with you.

Activity	Observe	Perform
History Taking	<input type="checkbox"/>	<input type="checkbox"/>
Physical Examination	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic Interpretation	<input type="checkbox"/>	<input type="checkbox"/>
Assessment/Plan of Care	<input type="checkbox"/>	<input type="checkbox"/>
Patient Education/Counseling	<input type="checkbox"/>	<input type="checkbox"/>
Assist with in-office procedures	<input type="checkbox"/>	<input type="checkbox"/>
Assist with surgical procedures	<input type="checkbox"/>	<input type="checkbox"/>
Perform patient call-backs	<input type="checkbox"/>	<input type="checkbox"/>
EMR documentation	<input type="checkbox"/>	<input type="checkbox"/>
Rounds	<input type="checkbox"/>	<input type="checkbox"/>
Other*	<input type="checkbox"/>	<input type="checkbox"/>

Scheduling Information

Please indicate the TOTAL NUMBER of students you would like to train during EACH rotation block below.
Should your availability change after this form has been submitted, please contact the program as soon as possible to avoid scheduling errors.

2024-2025 Rotation Block Schedule

Rotation Number	Start Date	End Date	Total Number of Students for this block
Rotation 1	5/28/24	7/2/24	
Rotation 2	7/8/24	8/13/24	
Rotation 3	8/19/24	9/26/24	
Rotation 4	9/30/24	11/5/24	
Rotation 5	11/11/24	12/19/24	
Rotation 6	1/6/25	2/11/25	
Rotation 7	2/17/25	3/27/25	
Rotation 8	3/31/25	5/6/25	

Notes:

<input type="checkbox"/>	I am unsure of my availability for 2024-2025; please contact me on an 'as-needed' basis for student placement (please check box).
	Is there a SPECIFIC STUDENT for whom you are providing this availability? If so, please provide his/her name here:
Osteopathic Medicine Podiatry	I am interested in precepting qualified students from other Midwestern Programs. These programs will contact you directly for your availability. (Check all that apply).

Hospital Affiliations

To avoid scheduling/credentialing errors, please contact the program as soon as possible, if any changes in hospital affiliation, practice location, etc. occur after this form has been submitted.

Do you see or treat patients in a hospital or free-standing surgical center?

YES

NO

Please note: Accurate hospital/surgicenter information is critical for student credentialing and University/hospital affiliation agreement processing. Please list the facilities that you anticipate the student to attend so we may proceed with credentialing. Students will only be credentialed at a maximum of four hospital sites. **Please list the four sites you attend most often. No student will be able to attend any facility that is not listed here, even in an observational capacity.**

Facility Name and address	Hospital System Name	Are you an employee of this facility?	#days/week you attend this facility	Name/ph # of hospital education coordinator	Do students need EMR access for this facility? (Y/N)
<i>eg. Tempe St. Luke's Hospital 1500 S. Mill Ave, Tempe, AZ</i>	<i>Iasis Healthcare</i>	<i>No</i>	<i>2</i>	<i>Mary Smith, Med Staff Svcs 555-5555</i>	<i>Yes</i>
1					
2					
3					
4					

Additional Comments:

Thank you so much for providing this opportunity for our students. The Clinical Year faculty are here to support your educational efforts; please contact us any time with questions or concerns. Phone: (623) 572-3680

Please email this form to: azpaclinical@midwestern.edu

For Program Use Only:

Office Use Only:

Date: _____

____ Approved by CC.

Init. _____

____ RMS

____ Typhon

____ Distance

____ Agmts. Initiated