

Preceptor Profile Form

Preceptor Profile: First Name Last Name **Preceptor Credentials:** __MD __DO __PA __NP __CNM __Other: ______ State License Number: Are you board certified? ___ Yes ___ No If certified, year of certification: _____ Specialty: Years of Experience: Do you routinely evaluate and manage patients for any of the following conditions: depression, anxiety, ADHD, nicotine dependence, substance abuse, and other behavioral concerns? Yes No Preferred method of Contact: Email Office Phone Office Fax Please identify the individual designated as our point of contact (if other than preceptor) (If preceptor then leave blank) First Name Last Name Title: Email: Phone:

Primary Practice Profile:

Practice/Clinical Site Name:			
Address: (Street)			
City	Ctoto	Zip Code:	
City:	State:		
Phone Number:	 Fax Nı	umber:	
Email:	Number of pa	Number of patients seen/day/provider:	
	<u>'</u>		
Practice Setting:			
InpatientOutpatientI	Pediatrics Surgery	Internal Medicine	
Family Medicine Emergency			
Behavioral Health Other:			
Additional Facilities:			
If a student will participate with you in a hospital, surgical center, emergency department,			
etc. other than the primary practice/office, we must have a complete affiliation agreement for each facility. Please provide the facility name and, if known, the contact name and			
phone number so that we may accomplish this prior to the student's arrival.			
Name of Facility, Type of Facility, Contact Person, Phone *			

Site Fees:	
Does your site charge for student experi	iences? If so, what is the rate?
Is there a preceptor honorarium for studyou or your facility? If yes, who is the pa	·
Student Requirements:	
Does your facility require?	
**Francis Marion University Physician Assistan tuberculosis screenings annually in November more frequent performance of these items.	
Security Clearance	Site/Facility specific student ID
Facility computer access or training	Student pre-placement drug test
**Pre-placement tuberculosis screening	**Proof of student background check
Other:	
Comments:	

Thank you for the opportunity to partner with you in the education of our students!

Please return completed form to:

Isaac Snapp, DMSc, MPAS, PA-C Clinical Coordinator isaac.snapp@fmarion.edu

