



# Preceptor Profile Form

## Preceptor Profile:

First Name

Last Name

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Preceptor Credentials:

MD  DO  PA  NP  CNM  Other: \_\_\_\_\_

State License Number:

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Are you board certified?  Yes  No

If certified, year of certification: \_\_\_\_\_

Specialty:

Years of Experience:

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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

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Title:

Email:

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Phone:

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## Site Fees:

Does your site charge for student experiences? If so, what is the rate?

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Is there a preceptor honorarium for student experiences that would be paid to you or your facility? If yes, who is the payee and what is the rate?


## Student Requirements:

Does your facility require...?

*\*\*Francis Marion University Physician Assistant Program performs background checks and tuberculosis screenings annually in November, please indicate only if your facility requires more frequent performance of these items.*

- |   |  |
|---|--|
| <input type="checkbox"/> Security Clearance                     | <input type="checkbox"/> Site/Facility specific student ID   |
| <input type="checkbox"/> Facility computer access or training   | <input type="checkbox"/> Student pre-placement drug test     |
| <input type="checkbox"/> **Pre-placement tuberculosis screening | <input type="checkbox"/> **Proof of student background check |
| <input type="checkbox"/> 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

