MOUNT ST. JOSEPH
UNIVERSITY
Physician Assistant Program

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/SITE INFORMATION

Preceptor Name/Credentials (MD, DO, PA, NP, etc.): _____

Preceptor Specialty: _____

Preceptor License #: _____

Board Certified: ☐Yes ☐No ☐Eligible

- DOB*: _____*Please provide DOB as required to obtain board certification verification.
- If PA-C, please list NCCPA#: _____

Preceptor Email: _____

Preceptor Phone#: _____

Primary Clinic/Facility Name: _____

Office Contact

Name: _____ Phone: _____ Email: _____

Office Address: _____

Settings (check all that apply):

☐Outpatient Clinic ☐Inpatient ☐Long-Term Care Facility ☐Emergency Department ☐Operating Room ☐ Other: _____

Patient Population (check all that apply):

☐ Pediatric ☐ Adult ☐ Geriatric ☐ OB/GYN ☐ Prenatal/perinatal

☐ Walk-ins ☐ Returning/follow-up ☐ New patients

Other hospital/surgery center/clinic locations where the student may participate in patient care:

_____

Typical weekly schedule for the student (days and hours worked – i.e. M-F 8-5):

_____

On call expectations? Yes ☐ No ☐
If yes, is a call room available? Yes ☐ No ☐
Please give further details regarding call expectations:

_____

Will another provider assist with precepting or cover on days the preceptor is off? Yes ☐ No ☐
If yes, what is their name and credentials? _____

Common procedures a student may assist with/perform?

_____

Most commonly seen disorders?

_____

Average # of patients seen daily by preceptor? _____ ***by student?*** _____

Additional learning opportunities: ☐ Lectures ☐ Grand Rounds ☐ Projects ☐ Other:

_____

Will the student have access to the following?
☐ *Facilities* – safe and secure environment, clinic workspace, area for personal belongings, parking
☐ *Patients* – history-taking, physical examination, diagnostic interpretation, treatment planning, education
☐ *Supervision* – preceptor verifies history-taking and physical exam, determines medical-decision-making, and reviews any notes written by the student
☐ *EMR access for the student* – ☐ None ☐ Read-only ☐ Ability to document
If no to any of the above, please elaborate:

Scheduling Preferences:
# of students per rotation: _____
# of students per calendar year: _____

Are you interested in being contacted about the possibility of giving a medical lecture at the PA program?
☐ Yes ☐ No Topics or subject areas: _____

COMMUNICATION/ONBOARDING INFORMATION

Preferred method of communication ☐ Email ☐ Phone

Contact for onboarding/student scheduling (i.e. preceptor directly and/or designated office contact)

Name: _____ Phone: _____ Email: _____

Are there specific paperwork or requirements that need to be completed prior to the start of the rotation (i.e. application, drug screen 30 days prior)?

_____

Resources or equipment students should bring:

_____

Required reading assignments/topics:

_____

How can students maximize their preparation for this rotation?

_____

Signature *(preceptor/office contact completing form):* _____

Date: _____

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

	This clinical site meets the minimum above stated criteria.
	This clinical site **does not** meet the minimum above stated criteria.

Date of initial review: _____

Signature of faculty member completing/reviewing the form: _____

Signature of Clinical Director: _____

Signature of Medical Director: _____

Review Date: _____ **Faculty Signature:** _____

Review Date: _____ **Faculty Signature:** _____

Review Date: _____ **Faculty Signature:** _____

State License

Preceptor License #_____Exp. date_____ State: _____

License verified unrestricted: Yes ☐ No ☐

Board Certification

MD/DO Certification #_____ Specialty _____ Source _____

PA NCCPA Certification #_____Exp. date_____

****Copies of licensing, board certification and NCCPA certification validated at time of initial preceptor/site qualification and verified prior to every rotation placement with preceptor***