Submit Form

SOUTH COLLEGE – SCHOOL OF PA STUDIES
Master of Health Science, Physician Assistant Program
Clinical Learning Preceptor Application

Submission Instructions: Please TYPE or PRINT clearly. Print and fax to 615-454-6156 or click the Submit Form button above to send by email. Please include a copy of your curriculum vitae.

PRECEPTOR NAME: LAST	FIRST	MIDDLE	**DEGREE**	☐**MD** ☐**DO** ☐**PA** ☐**NP** **Other**:
WORK PHONE #	EXT.	PAGER #	FAX #	E-MAIL ADDRESS
FACILITY/PRACTICE NAME		DEPARTMENT/SUITE		
ADDRESS: STREET		CITY	STATE	ZIP CODE
PRIMARY CONTACT (TO SCHEDULE STUDENTS)	CONTACT PHONE #	CONTACT FAX #	E-MAIL ADDRESS	

Have you ever acted as a Clinical Preceptor for a ☐MD ☐DO ☐PA ☐NP student before? ◯Yes ◯No
If yes please provide name of the college or university:

Are you board certified (if physician), or if mid-level provider, is your supervising physician board certified?
◯Yes ◯No Pending:
If Yes in what specialty?

1. State of Licensure:
2. Expiration Date: License, Certificate or Registration Number:
3. Has your license ever been suspended, revoked, restricted or not renewed ◯Yes ◯No
4. If Yes please explain:

Have your hospital privileges ever been suspended, revoked, restricted or not renewed ◯Yes ◯No
If Yes please explain:

Do you presently hold an adjunct or other Clinical Faculty Appointment ◯Yes ◯No
If yes, please specify faculty appointment and department:

Have you ever held a Teaching appointment with a medical/PA/NP school? ◯Yes ◯No
If yes, please specify faculty appointment and department:

How many years have you been practicing medicine in your present community?

Would the student be permitted to see patients in your practice under your supervision? ◯Yes ◯No

Indicate the number of examination rooms that are available to you on the days a PA student(s) will be at the clinical site:

Is there physical space available to permit the student to interview and examine patients? ◯Yes ◯No

Would you place any specific limitations on what he/she could do in your practice setting? ◯Yes ◯No
If Yes please describe:

Does your practice employ a PA? ◯Yes ◯No
If Yes for how long:
If No would you ever consider hiring a PA? ◯Yes ◯No
If Yes would you like our program to provide you with further information on our next visit concerning the hiring, role delineation and reimbursement of Physician Assistants ◯Yes ◯No

Are the patients and/or your staff aware of a Physician Assistants role & responsibilities? ◯Yes ◯No
If No:
Would you like some information concerning the role and responsibilities of Physician Assistants? ◯Yes ◯No

Please provide the names of any additional practitioners (***MD/DO/PA/NP***) who will share teaching responsibilities.

1.	2.
3.	4.

YOUR PRACTICE SPECIALTY: (PLEASE CHECK ALL THAT APPLY)

☐ Family Medicine	☐ Pediatrics	☐ General Surgery	☐ Behavioral Medicine
☐ Geriatrics	☐ Internal Medicine	☐ OB/GYN	☐ Emergency Medicine
☐ Long Term Care	☐ Other: _____		

PRACTICE TYPE: (PLEASE CHECK ONE)

◯ Hospital	◯ Non-Profit Health Clinic	◯ Community Health Clinic
◯ Public Health	◯ Indian Health Clinic	◯ Private Group Practice
◯ Long Term Care Center	◯ Migrant Health Clinic	◯ Private/Solo Practice
◯ Rural Health Clinic	◯ Military/Government	◯ Other: _____

PATIENT POPULATION

PLEASE APPROXIMATE THE PERCENTAGE OF YOUR PATIENT POPULATION BY: ***Age:*** *____% 0-4 ____% 5-12 ____% 13-18 ____% 19-27 ____% 28-39 ____% 40-64 ____% 65+* ***Gender:*** *Male_____% Female_____%*

What is the average number of outpatient encounter visits that you see per week? 30-55 ◯ 56-81 ◯ 82-107 ◯ 108+ ◯	**What is the average number of in-patients you see per week?** Hospital: _____ Long Term Care Facility: _____ OTHER_____

*Please describe other significant areas specific to your practice site (if applicable):

Is your practice located in an area designated as a Federal medical underserved area? ◯ Yes ◯ No ◯ Don't Know

Describe any special demographic/ethnic population for which you provide services:

PLEASE INDICATE THE DATE AND/OR DATES YOU WILL BE ABLE TO ACCOMMODATE A SOUTH COLLEGE PA STUDENT:

Preceptor	Duration	Rotation Dates	# of Students/Preceptorship		
	6 Weeks	See Attached	◯ 1	◯ 2	◯ 3
Surgical or Medical Sub-Specialties		See Attached	… 1	… 2	… 3

IF A PARTICULAR SOUTH COLLEGE STUDENT IS BEING CONSIDERED FOR A CLINICAL ROTATION AT YOUR FACILITY, PLEASE PLACE THE STUDENT'S NAME HERE. _____

If the South College PA student completing their clinical learning rotation with you will need hospital privileges while on rotation, please assist us by including the following information. This will allow South College School of PA Studies to pursue any necessary agreements or arrangements with the institution.

Medical Staff Office Contact: Telephone Number:	Name of the Facility (Hospital)
Complete Address:	Phone: Fax:
Would you like to be considered for Adjunct Clinical Faculty Status? ◯ Yes ◯ No ◯ Don't Know, Need More Information	Would you like to have an upcoming visit from a Faculty Member? ◯ Yes ◯ No

Please include a copy of your current curriculum vitae with this completed application ☐

Thank you for your ongoing efforts in providing excellence in medical education for our South College PA students.

This information is essential in the appropriate placement of our students. We look forward to following up with you.

OFFICE USE ONLY:

1.	Current clinical affiliation agreement (if applicable) has been signed and is on file	◯ Yes	◉ No
2.	Clinical Preceptor has access to the Preceptor Manual	◯ Yes	◉ No
3.	Clinical Site has been contacted by the program.	◯ Yes	◉ No
4.	Program has verified Preceptor Licensor Status	◯ Yes	◉ No
5.	Clinical Preceptor Current CV is on file with PA Program	◯ Yes	◉ No

South College
Growth • Direction • Excellence

AGREEMENT BETWEEN SOUTH COLLEGE
AND
PHYSICIAN PRECEPTOR SUPERVISOR FOR PHYSICIAN ASSISTANT STUDENT

1. SOUTH COLLEGE has a 27- month Master of Health Science, Physician Assistant Program. The Physician Assistant Program, at its discretion, permits students to engage in clinical learning rotations at approved clinical institutions and community-based sites.

2. Said Physician Assistant student(s) will be under the direct supervision and instruction of the Physician supervisor and will follow rules and regulations established by said Physician supervisor.

3. In said agreement, the Physician supervisor will:
   a. Make available the clinical and/or hospital facilities needed for the clinical learning experience of said South College Physician Assistant student during the period mutually agreed upon.
   b. Arrange, coordinate, and supervise the student's clinical learning experience according to the objectives established by the South College Physician Assistant Program.
   c. Complete for each student within one working week, all formative and summative evaluation forms, returning those forms to South College.

4. SOUTH COLLEGE will:
   a. Provide the Physician supervisor, upon request, with a letter documenting their experience for continuing medical education credit.
   b. Provide and maintain the student's personal records and reports necessary for conducting the student's clinical learning experience.
   c. Provide liability insurance for the physician assistant student for the period of the rotation.

5. Either party may terminate this agreement by written notification to all concerned. Should any difficulties arise, the physician supervisor should contact the Director of Clinical Education at 629-802-3281.

_____

Preceptor's Printed Name

_____ _____

Preceptor's Signature Date

_____ _____

Jason H. Huddleston, PA-C, MPAS Date
Director of Clinical Services

_____ _____

George F. Hillegas EdD, MPH, PA-C Date
Dean, School of Physician Assistant Studies