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 and Credentials (MD, DO, PA, NP, etc.):_____

Preceptor Specialty: _____ If MD, Board Certified?: Yes No Eligible DOB*:_____
*Please provide DOB as required to obtain board certification verification.

Supervising/Collaborating Physician's Name (if PA, NP, CNM): _____

Physician Specialty: _____ If MD, Board Certified?: Yes No Eligible DOB*:_____
*Please provide DOB as required to obtain board certification verification.

Preceptor Email: _____ Preceptor Phone: _____

Primary Clinic/Facility Name: _____

Office Contact:
Name: _____ Phone: _____ Email: _____

Office Address: _____

Settings:
☐ 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:

Clinical site profile

Typical weekly schedule for the student (ie. days and hours worked (M-F 8-5, etc.))

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

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JKG

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

Common procedures a student may assist with/perform?

Most commonly seen disorders?

Average number of patients seen daily by preceptor? _____ Average number by student? _____

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

Will the student have access to the following?

☐ Facilities – clinic workspace, necessary clinical settings, locker rooms, parking, safe and secure environment that is similar to staff
☐ Patients – history-taking, physical examination, diagnostic interpretation, treatment planning, education
☐ Supervision – preceptor verifies history-taking and physical exam, determines medical-decision-making
☐ Internet
If no to any of the above, please elaborate:

Will the student have Electronic Medical Record Access: ☐ None ☐ Read Only ☐ Ability to Document

Communication and onboarding information

Preferred method of communication ☐ Email ☐ Phone

Contact for Affiliation Agreement (name, email, phone) if different from office contact:

Name: _____ Phone: _____ Email: _____

Contact for onboarding/student scheduling (name, email, phone) if different from office contact:

Name: _____ Phone: _____ Email: _____

Scheduling Preferences:
Number of students per rotation: ___
Number of students per year: ___

Resources or equipment students should bring:

Required reading assignments/topics:

How can students maximize their preparation for this rotation?

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

Signature of faculty member completing form: _____

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

Original Date of Evaluation: _____

Clinical Director: _____

Medical Director: _____

Review Date: _____ Faculty Signature: _____

Review Date: _____ Faculty Signature: _____

Review Date: _____ Faculty Signature: _____

	The preceptor received the preceptor handbook and rotation syllabus
	This training site meets the minimum above stated criteria.
	This training site does not meet the minimum above stated criteria.

State License

Preceptor License #/Exp date_____ State: _____ License verified unrestricted: Yes ☐ No ☐

Supervising MD License #/Exp date_____State: _____ License verified unrestricted: Yes ☐ No ☐

Board Certification

MD/Supervising MD Certification #_____ Specialty _____ Source _____

If not board certified, CV reviewed by Clinical Director with experience/qualifications appropriate for field of instruction
Yes ☐ No ☐

PA NCCPA Certification # _____ Expiration 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