EVMS

PHYSICIAN ASSISTANT PROGRAM

# PRECEPTOR PROFILE

## PRECEPTOR INFORMATION:

DATE COMPLETED:

| | | |
|---|---|---|
| NAME: | LICENSE #: | STATE: |
| CREDENTIAL: Select One... | BOARD CERTIFIED: Select One... | AREA OF CERTIFICATION: (i.e. - specialty) |
| NCCPA # (IF A PA): | NUMBER OF YEARS PRACTICING IN YOUR AREA OF CERTIFICATION? | |
| EMAIL ADDRESS: | CONTACT NUMBER: | |

## FOR PA-C/NP - ADDITIONAL INFORMATION REGARDING SUPERVISING PHYSICIAN:

| | | |
|---|---|---|
| SUPERVISING PHYSICIAN: | LICENSE #: | STATE: Select One... |
| CREDENTIAL: Select One... | AREA OF CERTIFICATION: | |
| NUMBER OF YEARS PRACTICING IN AREA OF CERTIFICATION: | | |

## PRACTICE INFORMATION:

| | | | |
|---|---|---|---|
| SITE NAME: | | | |
| ADDRESS: | CITY: | STATE: Select One... | ZIP: |
| OFFICE POINT OF CONTACT: | POSITION/FUNCTION: | | |
| EMAIL ADDRESS: | | | |
| PHONE #: | FAX #: | OTHER: | |
| AVERAGE NUMBER OF PATIENTS SEEN PER DAY? | WILL THE STUDENT HAVE ACCESS TO EMR/PATIENT CHARTS? Select One... | | |
| PATIENTS SEEN IN HOSPITAL? ◉ YES ○ NO<br>IF "YES" PLEASE LIST HOSPITAL(S) YOU WILL TAKE THE STUDENT TO (PLEASE LIMIT TO 2): | | | |
| 1. | | | |
| 2. | | | |
| ARE YOU EMPLOYED BY A CONTRACTING GROUP OUTSIDE OF THIS SITE? | | | |
| GROUP NAME (IF APPLICABLE): | | | |

## STUDENT EXPECTATIONS:

| | | |
|---|---|---|
| LOCATION & TIME TO REPORT (FIRST DAY OF ROTATION): | | |
| HOURS (EXPECTED AVERAGE = 40 HRS/WK): | HRS PER DAY | HRS PER WEEK |
| ON-CALL REQUIREMENTS: | WEEKEND REQUIREMENTS: | |
| SITE SPECIFIC REQUIREMENTS: (E.G. IMMUNIZATIONS, BLS/ACLS, HIPAA TRAININGS, ETC) | | |
| YOUR RECOMMENDATIONS FOR A STUDENT TO PREPARE IN ADVANCE FOR THIS ROTATION (E.G. - REFERENCE BOOK, ETC.): | | |
| PRECEPTOR/POC SIGNATURE: | DATE SIGNED: | |