Preceptor Form

☐ **Primary Preceptor:** MD or DO who will take responsibility for the majority of the student's clinical instruction AND whose practice is in primary care medicine.

☐ **Supplemental Preceptor:** MD or DO whose practice supplies required learning experiences that are not sufficiently provided by the Primary Preceptor. Example: Pediatrics, Women's Health

☐ **Assistant Preceptor:** PA, NP, CNM or other licensed professional, working under the supervision of an MD/DO, who provides important, regular and recurring training of the student in primary care. *Every Assistant Preceptor must be accompanied by the name of an MD or DO who will agree to supervise the student's training.*

☐ **Facility:** (check if the student will be precepting at a facility such as multi-specialty clinic, hospital, etc. See Section 2 below)

Student Name	Faculty Advisor
Desired Clinic/Rotation start date:	Site Visitor

1. Preceptor Information

Preceptor Name	☐ MD/DO ☐ NP ☐ PA ☐ Other	☐ Primary ☐ Supplemental ☐ Asst. Preceptor

California License #: Expiration date:

Clinic Name

Street Address

City: State/ Zip: County:

Tel: Fax:

*Email: Cell:

Please add email address to receive free access into the Stanford Medical School Lane Library

Practice Specialty:

☐ General Practice	☐ Family Practice	☐ Pediatrics	☐ ER
☐ Internal Medicine	☐ OB/GYN	☐ Urgent Care	☐ Other
☐ Skilled Nursing Facility	☐ Orthopedics		
☐ Surgery	☐ Inpatient		

Precepting Experience:

Have you previously precepted a PCAP student? ☐ Yes ☐ No

If "yes" please provide student's name:

Current Hospital Staff Privileges

	Location (City)	Hospital Staff Status
facility		
facility		

2. Insurance Informance

**Provide the full name of your malpractice insurance carrier and amount of coverage:		
Has your medical license ever been revoked, suspended or limited in any manner?	☐ Yes*	☐ No
Have you been party to a malpractice action during the past five years?	☐ Yes*	☐ No
Have your hospital privileges ever been suspended, revoked, restricted, or not renewed?	☐ Yes*	☐ No
***If you answered YES to any of the above questions an explanation MUST be submitted with this application. We will verify all professional credentials with the appropriate state licensing Board. (Please attach explanation)**		

3. Work Hours and Facility Information

Avg. # of outpatients **you see per day** in clinic	_____	
Avg. # of inpatients **you see per day** in hospital	_____	
Avg. # of patients **you see per day** in nursing home	_____	
Hours per week you work in the following:		
Office/clinic:	_____	
Hospital:	_____	
Nursing home/SNF:	_____	
Other:	_____	
Total hours per week:	_____	
# of exam rooms available to you on days when this student will be in the office:		
Can a student occupy an exam room continuously for up to 7-8 hours on preceptorship days?	☐ Yes	☐ No
If "No", for how many hours will the student be able to utilize an exam room on preceptorship days?	# hours	
Will the student be able to write notes in clinic charts?	☐ Yes	☐ No
Dictate?	☐ Yes	☐ No
Make entries in electronic records?	☐ Yes	☐ No
If you are a PA, NP or CNM hoping to serve as an Assistant Preceptor have you made arrangements for MD/DO supervision?	☐ Yes	☐ No
If "Yes" please list the name(s) and license # of the MD/DO who will assume ultimate responsibility for the student being trained by an Assistant Preceptor AND make sure physician signature appears in Section 6.	_____	
	_____	
Does the facility have an office laboratory available for training the student in performing wet mounts, urinalaysis, hemoglobin/hematocrit, etc?	☐ Yes	☐ No

4. Facility Information

Complete this section if the student will be in a facility that has an office that coordinates training or requires a facility contract to be in place. Fill out this section for hospital and emergency room rotations.

Facility Name

Street Address

City State/Zip County

☐ Contracting Department ☐ Education Department ☐ Medical Staff Office
☐ Nursing ☐ Human Resources ☐ Other (describe)
☐ Facility/Clinic Manager Administration

Contact Name:

Tel: Email: Cell: Fax:

Does your facility require a contract? ☐ Yes ☐ No ☐ Unsure
Is one in place? ☐ Yes ☐ No

If "yes", indicate the date contract expires:

5. Practice Information & Demographics

Community Size: ☐ population < 4,220 (exceptionally rural) ☐ population < 6,995 (mid-rural) ☐ population < 13,600 (rural)
☐ Other (describe)

Estimate the percentage of patient population seen at your facility for each of the following categories:

Medicare % Medi-Cal % Medically Indigent % (receive services at no charge)

Describe any special demographic or ethnic population for which you provide services, including percent of your practice for each group.

Primary language(s) of clinic population:

List special language skills ***required*** of your clinicians:

Type of practice:

Check ONE that best describes your practice:

☐ HMO ☐ Private solo practice ☐ Military Clinic
☐ Managed Care Organization ☐ Private group practice ☐ Hospital-based clinic
☐ Other

Underserved type: Check **ALL** that describe your practice service, location or patient population

☐ **AUN** - Area of unmet need
☐ **CC** - CA licensed Community Clinic
☐ **CHC** - Bureau of Primary Health Care Community Hlth Ctr
☐ **CNTY** - County Public Healh Facility or Jail
☐ **FC** - CA licensed Free Clinic
☐ **FQHC** - Federally Qualified Health Center
☐ **FQHC-LA** - Federally Qualified Health Center Look Alike
☐ **HO** - Health Care for Homeless
☐ **HPSA** - Health Professional Shortage Area
☐ **MHC** - Migrant Health Center
☐ **MUA** - Medically Underserved area
☐ **MUP** - Medically underserved population
☐ **NHSC** - National Health Service Corps
☐ **PHPC** - Public Housing Primary Care
☐ **RHC** - Rural Health Center
☐ **TRHP** - Tribally Run Indian Health Service
☐ **UIHC** - Urban Indian Health Center

Note: PCAP staff will confirm the accuracy of this information

6. Signatures

If approved to serve as ☐ Preceptor ☐ Assistant Preceptor (check one)

I agree to:

- provide student training and supervision in accordance with California State Law
- provide for a variety of patient encounters necessary for an appropriate learning experience review regularly the student's objectives to identify the focus of his/her studies and assure that the clinical experience meets the student's learning goals
- review regularly the student's objectives to identify the focus of his/her studies and assure that the clinical experience meets the student's learning goals
- provide the agreed upon hours of experience required for the student's training
- be on site during the student's hours for supervision, consultation and teaching
- ensure that the student does not practice beyond his/her competency or legal authority
- review and countersign every student's medical record within 24 hours; IF **Assistant Preceptor**, also ensure that the supervising physician reviews and countersigns within 7 days
- provide feedback to the student and Program regarding student performance; this includes quarterly written evaluations and/or end-of-rotation evaluations
- notify the student's Faculty Advisor and Site Visitor at the earliest sign of a problem to assure timely resolution
- acknowledge that the student will be providing PCAP with a written evaluation of the preceptorship at the end of the perceptorship or rotation

Signature		
	☐ MD/DO ☐ NP** ☐ PA** ☐ Other**	☐ Primary ☐ Supplemental ☐ Asst. Preceptor

****if one of these boxes are marked please have supervising physician read and sign below.**

Print Name	Date:

****Attention Physicians who have agreed to serve as the ultimate supervisor of an Assistant Preceptor: Your signature below is required and indicates that you have read the information provided on this form and acknowledge you assume ultimate responsibility for the student being trained by an Assistant Preceptor. Attach additional sheets if more than one physician will be supervising the Assistant Preceptor.**

Supervisor of Asst. Preceptor	License #	Date

Approved by:

Faculty Advisor	Date
Site Visitor	Date
PCAP	Date

Stanford University/Foothill College Primary Care Associate Program
Family and Community Medicine
Stanford University
1215 Welch Road, Modular G
Palo Alto, CA 94305-5408
Attn: Cynthia Ahrendsen, Preceptor Coordinator fax: 650-723-9692 office: 650-723-8267

INFORMATION RELEASE AUTHORIZATION

For purposes of my participation in the Primary Care Associate Program I understand that PCAP must verify my professional training, experience and conduct. My signature below authorizes representatives of the Primary Care Associate Program at Stanford School of Medicine to contact individuals, agencies and hospitals which have been named in this document, as well as medical staff, medical schools, hospitals or medical centers, training programs, medical societies, professional associations, professional liability insurance companies and licensing authorities, in jurisdictions in which I have trained, resided or practiced, for the evaluation of my professional competence, experience, character and good judgement. I consent to the communication of information and documents between PCAP and the agents/agencies listed above.

I agree to release Foothill College, Stanford University School of Medicine and the Primary Care Associate Program from civil liability regarding processing of my approval form. I release from liability any and all individuals and organizations who provide information to PCAP in good faith without malice concerning my professional competence, ethics, character and other qualifications to be a clinical preceptor in the Primary Care Associate Program.

I hereby affirm that the information furnished by me is true to the best of my knowledge and is furnished in good faith.

Preceptor Signature

- ☐ MD/DO
- ☐ NP**
- ☐ PA**
- ☐ Other**

- ☐ Primary
- ☐ Supplemental
- ☐ Asst. Preceptor

****if one of these boxes are marked please have supervising physician read and sign below.**

Print Name: License #: Date:

Attention Physicians who have agreed to serve as the ultimate supervisor of an Assistant Preceptor: Your signature below is **required** and indicates that you have read the information provided on this form and acknowledge you assume ultimate responsibility for the student being trained by an Assistant Preceptor. Attach additional sheets if more than one physician will be supervising the Assistant Preceptor.

Supervisor of Asst. Preceptor: License #: Date: