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: ______________________ MD/DO Board Certified? ☐Yes ☐No ☐Eligible DOB*:________
*Please provide DOB as required to obtain board certification verification.

Preceptor Email: _________________________________ Preceptor Phone: _____________________________

Primary Clinic/Facility Name: ____
If preceptor is PA-C please list NCPPA #______________________________
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:

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

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SAS

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:

Student will have access to the following. Check all that apply.

☐ 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:

EMR access for the student: ☐ 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 preceptor/office contact completing the form:

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

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 Certifications

MD/DO 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