

COLLEGE OF HEALTH PROFESSIONS Department of Physician Assistant Studies

Preceptor Profile & Agreement Form

Preceptor Full Name		DOB					
Title: DMD	DO	\Box_{PA}	\Box NP		LCSW	□Other	
Email (required)							
Preferred Phone #Work Phone #							
Specialty	State of Lic			nse		License	;#
Are you/your supervising Physician Board Certified? YES Please list area of certification							
Please attach a current copy of your CV, board certification, other certification and current state licensure.							
Please list the name of your supervising physician (if applicable)							
Legal Name of Organiza	ation						
Street City/State's office							
City/State/Zip							
County Phone () Fax ()							
Office Manager Email							
Who will be the primary contact? Preceptor Office Manager Other							
Preceptor/Student Schedule: Please list the days and times of the student rotation schedule:							
Days Sunday	Times (e.g. 8:00 a.m5:00 p.m.)		(1.5.)//	Days Times Thursday			
Monday				Friday			
Tuesday			1.7.22	Saturday			
Wednesday				· ·			
Only complete the Hospital Affiliation section if the Student will be accompanying the Preceptor at the Hospital Facility.							
Hospital Affiliations:							
-		Hospital Credentia Contact Persor	0		Email		Phone & Address
Preceptor Questionnaire							
1. Have you ever served as a clinical preceptor for PA or MD students?					$^{\text{Yes}}$ s^{Yes}	No	
2. Will you be able to provide at least 32 hours/week of clinical instruction?					Yes Yes	No	

We, at Mercer University, thank you for your time and dedication to educating future Physician Assistants. We look forward to working with you.

Please return forms via email or if you have any questions, please contact our office via email: paclinical@mercer.edu