MERCER UNIVERSITY

COLLEGE OF HEALTH PROFESSIONS

Department of Physician Assistant Studies

Preceptor Profile & Agreement Form

Preceptor Full Name _____ DOB _____

Title: ☐MD ☐DO ☐PA ☐NP ☐LCSW ☐Other

Email (required) _____

Preferred Phone # _____ Work Phone # _____

Specialty _____ State of License _____ License # _____

Are you/your supervising Physician Board Certified? ☐YES ☐NO 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 Organization _____

must be listed as is on file with the Secretary of State's office

Street _____ 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	Times (e.g. 8:00 a.m.-5:00 p.m.)	Days	Times
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Only complete the Hospital Affiliation section if the Student will be accompanying the Preceptor at the Hospital Facility.

Hospital Affiliations:

Facility Name	Hospital Credentialing Contact Person	Email	Phone & Address

Preceptor Questionnaire

1. Have you ever served as a clinical preceptor for PA or MD students? Yes ☐ No ☐
2. Will you be able to provide at least 32 hours/week of clinical instruction? 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