

APPLICATION FOR PRECEPTORSHIP

Instructions:

1. **New** Preceptors: please complete this entire application.
2. **Repeat** Preceptors within the past five years: please complete only pages 1 and 5.

PRIMARY PRECEPTOR
(MD or DO Only)

SUPPLEMENTARY PRECEPTOR
(MD, DO, NP or PA)

Student or Applicant Name: _____
(Last) (First)

Section 1: Preceptor Information

Preceptor Name: _____
(Last) (First) (Middle)

MD DO NP PA (Check) **California License Number** _____
(Do not leave blank)

Facility/Clinic Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Telephone: _____ Fax # _____ E-mail: _____

Practice Specialty: Family Practice OB/GYN Urgent Care/ER
 Internal Medicine Pediatrics Other: _____

Board Certification:

1. Are you currently certified by the American Board of Family Practice? Yes No

or

2. Were you previously certified by the American Board of Family Practice? Yes No

If you are not currently board certified, please include a photocopy of your certification.

3. Are you currently or previously board certified in any other specialty? Yes No

If so, which specialty? _____

4. Have you trained a UC Davis FNP/PA student? Yes No

If so, please provide student's name(s) _____

5. Do you presently hold a **Volunteer Clinical Faculty** appointment with the University of California, Davis, **Department of Family and Community Medicine**? Yes No

FOR PROGRAM USE ONLY

CENSUS TRACT # _____ **CODING** _____ **MSSA#** _____

Section 2: Practice Demographics

- Please approximate the percentage of patient population seen at your facility for each of the following categories:
_____ % Medicare
_____ % Medi-Cal
_____ % Medically Indigent (those who receive services at no charge)
- Describe any special demographic or ethnic population for which you provide services:

- _____ % of practice for these special demographic or ethnic populations.

Section 3: Practice Information

- Please check the **primary** type of practice:
 Health Maintenance Organization (HMO) Private Solo Practice (PS) Military (MI)
 Managed Care Organization (MCO) Private Group Practice (PGP) Hospital Clinic (HC)
 Other type of practice: _____
- Is your practice site a **State of California Designated**:
 Rural Health Clinic
 California Rural Hospital
 County or Public Health Agency or Jail
 OSHPD (Office of State Health Planning Department) designated underserved clinic
 Other state designated or funded clinic (Describe: _____)
- Is your practice site a **US Federally Designated**:
 Community Health Center
 FQHC (Federally Qualified Health Center)
 Homeless Health Care Site
 Public Housing Primary Care Program
 Rural Health Clinic
 Indian Program:
 Tribally Run Health Program
 Indian Health Service Site
 Urban Indian Health Center
 Migrant Health Center/National Center for Farmworker Health
 Other federally designated or funded clinic or health site (Describe: _____)

Section 4: Patient Numbers and Work Hours

- State the average number of outpatients **you see PER WEEK**. _____
(as an individual practitioner)
- State the average number of inpatients **you see per day** in a: hospital: _____ nursing home: _____
- Indicate the number of hours **per week** that **you** work in the following areas:
Office/Clinic _____ hours/week
Hospital _____ hours/week
Nursing Homes _____ hours/week
Other: _____ hours/week
TOTAL hours per week **you** work _____

Section 7: Medical School and Affiliations

Medical/PA/NP School: _____ Year MD/DO/NP/PA awarded: _____

Internship: _____
(Location) (Years) (Type)

Residency Training: _____
(Location) (Years) (Specialty)

Have you ever held an appointment with any medical school faculty? Yes No

School Department Title Dates

▪ Current Hospital Staff Privileges Location Hospital Staff Status

Section 8: Professional References

Please list three physicians who have knowledge of your clinical skills and background.

1. Name: _____ Telephone No.:() _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

2. Name: _____ Telephone No.:() _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

3. Name: _____ Telephone No.:() _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Section 9: Insurance Information

1. Has your medical license ever been revoked, suspended or limited in any manner? Yes* No
2. Have you been party to a malpractice action during the past five years? Yes* No
3. Have your hospital privileges ever been suspended, revoked, restricted, or not renewed? Yes* No
4. Provide the full name of your malpractice insurance carrier: _____
(Do not leave blank)

Preceptors are covered by the University of California professional liability only when they are precepting the FNP/PA student with whom they have an approved MOU and only for problems generated by the FNP/PA student.

***If you answered YES to any of the questions above, an explanation must be submitted with this application. An affirmative answer to any of these questions will not automatically preclude this application from being processed.**

Section 10: Additional Information

1. How long have you known the student/applicant? _____
2. What is your professional relationship with the student/applicant? Please describe: _____

3. Indicate the number of hours per week **you** plan to spend with the student/applicant: _____
4. Indicate the number of months **you** plan to teach the student/applicant: _____
5. If you are planning to be a "**primary**" preceptor for a student, you would be principally responsible for his/her clinical education. Students are expected to complete 20-24 hours per week clinical practice time. Do you feel you will be able to devote this amount of time to the student's education?
 Not Applicable Yes No

Section 11 Signature

My signature below authorizes the Regents of the University of California or their representatives to contact individuals, agencies, and hospitals which I have named on page five of this document. I agree to release the University of California from civil liability regarding the processing of my application. Finally, I hereby release from liability any and all individuals and organizations that provide information to the University of California, Davis in good faith without malice concerning my professional competence, ethics, character and other qualifications to be a preceptor in the FNP/PA Program, and I hereby consent to the release of such information.

Preceptor Signature

Date

Mail to:
University of California, Davis
Family Nurse Practitioner/Physician Assistant Program
TICON II Bldg.
2516 Stockton Boulevard, Suite 254
Sacramento, California 95817

Thank you for your time and assistance in completing this application for preceptorship. Should you have any questions or wish further information regarding this application, please call the FNP/PA Program office at (916) 734-3551.