# Heritage University Physician Assistant Program

**Clinical Preceptor Profile**

**Preferences:**

How many PA students are you willing to precept each year (12 months) for Family Medicine? \_\_\_\_\_ General Surgery? \_\_\_ Pediatrics? \_\_\_\_ Psychiatry/Behavioral Health? \_\_\_ OB/GYN? \_\_\_ Emergency Medicine? \_\_\_\_ Internal Medicine (inpatient and or outpatient)? \_\_\_\_ Other? \_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any months that you prefer to NOT to have a student?

|  |  |
| --- | --- |
| **Name:** | **Title: MD, DO, PA, NP (Circle one) Other (indicate)** |
| **Specialty:** | **Medical Board License Number:** |
| **Mailing Address:** | **City, State, Zip:** |
| **Phone:** | **Fax:** |
| **Email:** | **Cell:** |
| **Office Manager (or person to contact when scheduling a student):** | |
| **Office Manager Email:** | |
| **Office Manager Phone:** | |
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| --- | --- |
| **Credentialing:**  **Please list all facilities that students will need to be credentialed.** | **Estimated % of cases at each facility:** |
|  |  |
| **Contact Name and Phone to credential at each facility:** |  |
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**ABOUT YOUR PRACTICE:**

Do you have any colleagues working with you that may be participating in the precepting of our students? If yes, please provide their name(s) and whether MD, DO, PA, or NP:

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Does your practice maintain professional liability insurance? (Circle one) Yes No

Please email or fax these documents to: Samantha Visaya-Credentialing Specialist Email: [Visaya\_S@heritage.edu](mailto:Visaya_S@heritage.edu) or Fax: 509-865-8560

Approved:

Clinical Coordinator

Date: