

SOUTH COLLEGE – SCHOOL OF PA STUDIES

Master of Health Science, Physician Assistant Program

Clinical Learning Preceptor Application

Please TYPE or PRINT clearly and fax back to
1-470-322-1500 ATTN: Elizabeth Massey
ALONG with a copy of your CV
Or email emassey1@south.edu

PRECEPTOR NAME: LAST		FIRST	MIDDLE	DEGREE	MD <input type="checkbox"/>	DO <input type="checkbox"/>	PA <input type="checkbox"/>	NP <input type="checkbox"/>	Other: <input type="checkbox"/>
WORK PHONE #	EXT.	PAGER #	FAX #	E-MAIL ADDRESS					
FACILITY/PRACTICE NAME				DEPARTMENT/SUITE					
ADDRESS: STREET		CITY		STATE		ZIP CODE			
PRIMARY CONTACT (TO SCHEDULE STUDENTS)		CONTACT PHONE #		CONTACT FAX #		E-MAIL ADDRESS			
Have you ever acted as a Clinical Preceptor for a MD DO PA NP student before?									Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes please provide name of the college or university:									
Are you board certified (if physician), or if mid-level provider, is your supervising physician board certified?									
Yes <input type="checkbox"/> No <input type="checkbox"/> Pending: <input type="checkbox"/>									
If Yes in what specialty?									
1. State of Licensure:									
2. Expiration Date: License, Certificate or Registration Number:									
3. Has your license ever been suspended, revoked, restricted or not renewed									Yes <input type="checkbox"/> No <input type="checkbox"/>
4. If Yes please explain:									
Have your hospital privileges ever been suspended, revoked, restricted or not renewed									Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes please explain:									
Do you presently hold an adjunct or other Clinical Faculty Appointment									Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify faculty appointment and department:									
Have you ever held a Teaching appointment with a medical/PA/NP school?									Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify faculty appointment and department:									
How many years have you been practicing medicine in your present community?									
Would the student be permitted to see patients in your practice under your supervision?									Yes <input type="checkbox"/> No <input type="checkbox"/>
Indicate the number of examination rooms that are available to you on the days a PA student(s) will be at the clinical site:									
Is there physical space available to permit the student to interview and examine patients?									Yes <input type="checkbox"/> No <input type="checkbox"/>
Would you place any specific limitations on what he/she could do in your practice setting?									Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes please describe:									
Does your practice employ a PA?									Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes for how long:									
If No would you ever consider hiring a PA?									Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes would you like our program to provide you with further information on our next visit concerning the hiring, role delineation and reimbursement of Physician Assistants									Yes <input type="checkbox"/> No <input type="checkbox"/>
Are the patients and/or your staff aware of a Physician Assistants role & responsibilities?									Yes <input type="checkbox"/> No <input type="checkbox"/>
If No:									
Would you like some information concerning the role and responsibilities of Physician Assistants?									Yes <input type="checkbox"/> No <input type="checkbox"/>
Please provide the names of any additional practitioners (MD/DO/PA/NP) who will share teaching responsibilities.									
1.				2.					
3.				4.					

YOUR PRACTICE SPECIALTY: (PLEASE CHECK ALL THAT APPLY)

<input type="radio"/> Family Medicine	<input type="radio"/> Pediatrics	<input type="radio"/> General Surgery	<input type="radio"/> Behavioral Medicine
<input type="radio"/> Geriatrics	<input type="radio"/> Internal Medicine	<input type="radio"/> OB/GYN	<input type="radio"/> Emergency Medicine
<input type="radio"/> Long Term Care	<input type="radio"/> Other: _____		

PRACTICE TYPE: (PLEASE CHECK ONE)

<input type="checkbox"/> Hospital	<input type="checkbox"/> Non-Profit Health Clinic	<input type="checkbox"/> Community Health Clinic
<input type="checkbox"/> Public Health	<input type="checkbox"/> Indian Health Clinic	<input type="checkbox"/> Private Group Practice
<input type="checkbox"/> Long Term Care Center	<input type="checkbox"/> Migrant Health Clinic	<input type="checkbox"/> Private/Solo Practice
<input type="checkbox"/> Rural Health Clinic	<input type="checkbox"/> Military/Government	<input type="checkbox"/> Other: _____

PATIENT POPULATION

PLEASE APPROXIMATE THE PERCENTAGE OF YOUR PATIENT POPULATION BY: **Age:** % 0-4 % 5-12 % 13-18
 % 19-27 % 28-39 % 40-64 % 65+ **Gender:** Male_ % Female_ %

What is the average number of outpatient encounter visits that you see per week?

What is the average number of in-patients you see per week?

30-55 56-81 82-107 108+

Hospital: _____
 Long Term Care Facility: _
 OTHER _____

*Please describe other significant areas specific to your practice site (if applicable):

Is your practice located in an area designated as a Federal medical underserved area? Yes No Don't Know

Describe any special demographic/ethnic population for which you provide services:

PLEASE INDICATE THE DATE AND/OR DATES YOU WILL BE ABLE TO ACCOMMODATE A SOUTH COLLEGE PA STUDENT:

Preceptor	Duration	Rotation Dates	# of Students/Preceptorship		
Surgical or Medical Sub-Specialties	6 Weeks	See Attached	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
		See Attached	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

IF A PARTICULAR SOUTH COLLEGE STUDENT IS BEING CONSIDERED FOR A CLINICAL ROTATION AT YOUR FACILITY, PLEASE PLACE THE STUDENT'S NAME HERE.

If the South College PA student completing their clinical learning rotation with you will need hospital privileges while on rotation, please assist us by including the following information. This will allow South College School of PA Studies to pursue any necessary agreements or arrangements with the institution.

Medical Staff Office Contact: _____	Telephone Number: _____	Name of the Facility (Hospital) _____
Complete Address: _____	Phone: _____	Fax: _____
Would you like to be considered for Adjunct Clinical Faculty Status?	Would you like to have an upcoming visit from a Faculty Member? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know, Need More Information		

Please include a copy of your current curriculum vitae with this completed application

Thank you for your ongoing efforts in providing excellence in medical education for our South College PA students. This information is essential in the appropriate placement of our students. We look forward to following up with you.

OFFICE USE ONLY:		
1. Current clinical affiliation agreement (if applicable) has been signed and is on file	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Clinical Preceptor has access to the Preceptor Manual	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Clinical Site has been contacted by the program.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4. Program has verified Preceptor Licensor Status	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Clinical Preceptor Current CV is on file with PA Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>



**South College Physician Assistant Program
Clinical Rotations for Clinical Year 2021 – Class of 2021**

Preceptor's Name: _____

Specialty: _____

Address: _____

Please choose your specialty:

- | | | |
|--------------------------------------|------------------------------------|---|
| <input type="radio"/> Woman's Health | <input type="radio"/> Internal Med | <input type="radio"/> Cardiology |
| <input type="radio"/> Gen Surgery | <input type="radio"/> Emergency | <input type="radio"/> Pulmonology |
| <input type="radio"/> Behavioral | <input type="radio"/> Pediatrics | <input type="radio"/> Gastroenterology |
| <input type="radio"/> Family Med | <input type="radio"/> Geriatrics | <input type="radio"/> Other, specify: _____ |

WE WILL WORK WITH YOUR CLINICAL SCHEDULE

Rotation	Dates	Student Callback/Exams	Preceptor Availability
Rotation 1	January 4 – Feb 10	February 11-12	
Rotation 2	February 15– March 24	March 25-26	
Rotation 3	March 29 – May 4th	May 5-6	
Rotation 4	May 10 - June16	June17-18	
Rotation 5	June 21 - July 28	July 29-30	
Rotation 6	August 2 - September 8	September 9-10	
Rotation 7	September 13 – October 20	October 21-22	
Rotation 8	October 25 – December 1	December 2-3	

How many of your available dates would you like to have a student?

All marked

Every other one

_____ # of Rotations

Other Important Clinical Dates

Clinical Summative Review

December 6th- 10th

Graduation ceremony

December

Preceptor Signature _____

Date _____



AGREEMENT BETWEEN SOUTH COLLEGE
AND
PHYSICIAN PRECEPTOR SUPERVISOR FOR PHYSICIAN ASSISTANT STUDENT

1. SOUTH COLLEGE has a 27- month Master of Health Science, Physician Assistant Program. The Physician Assistant Program, at its discretion, permits students to engage in clinical learning rotations at approved clinical institutions and community-based sites.
2. Said Physician Assistant student(s) will be under the direct supervision and instruction of the Physician supervisor and will follow rules and regulations established by said Physician supervisor.
3. In said agreement, the Physician supervisor will:
 - a. Make available the clinical and/or hospital facilities needed for the clinical learning experience of said South College Physician Assistant student during the period mutually agreed upon.
 - b. Arrange, coordinate, and supervise the student's clinical learning experience according to the objectives established by the South College Physician Assistant Program.
 - c. Complete for each student within one working week, all formative and summative evaluation forms, returning those forms to South College.
4. SOUTH COLLEGE will:
 - a. Provide the Physician supervisor, upon request, with a letter documenting their experience for continuing medical education credit.
 - b. Provide and maintain the student's personal records and reports necessary for conducting the student's clinical learning experience.
 - c. Provide liability insurance for the physician assistant student for the period of the rotation.
5. Either party may terminate this agreement by written notification to all concerned. Should any difficulties arise, the physician supervisor should contact the Director of Clinical Education at 865-288-8317.

Preceptor's Printed Name

Preceptor's Signature

Date

Elizabeth Massey, MHS, PA-C
Associate Director of Clinical Services

Date

Russ Dailey, MMS, PA-C
Director of Clinical Services, School of Physician Assistant Studies
Knoxville and Atlanta

Date