



## NEW PRECEPTOR / CLINICAL INSTRUCTOR APPLICATION FORM

### CLINICAL TRAINING SITE INFORMATION

Site Name: \_\_\_\_\_ Specialties: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Website (if applicable): \_\_\_\_\_

Contact Person: \_\_\_\_\_ Job Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

- Preferred method of contact: Phone  OR Email
- Please check all that apply:  
 MUA  HPSA  Medicaid  Ambulatory Care  Multi Disc Site
- National Health Service Corps Designated Site: Yes  No
- If not, would you like to receive information about this program? Yes  No

### PRECEPTOR INFORMATION

Salutation: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Title: \_\_\_\_\_ Specialty: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Board Certified: Yes  No  Email: \_\_\_\_\_

- Would you like to receive email literature alerts from our Outreach Librarian? Yes  No
- National Health Service Corps Scholarship Recipient: Yes  No

### HOSPITAL AFFILIATION INFORMATION

- Please list all hospitals which have granted you privileges:

Name of Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person/Department: \_\_\_\_\_ Phone No: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person/Department: \_\_\_\_\_ Phone No: \_\_\_\_\_

**COMMUNITY INFORMATION**

\_\_\_\_\_ % Indigent      \_\_\_\_\_ % Middle Income      \_\_\_\_\_ % Above Middle Income

▪ Language(s) Spoken in the Office: \_\_\_\_\_ Access to a translator? \_\_\_\_\_

**PRECEPTING DETAILS**

▪ Would you prefer a student with a particular medical background or specialized training?

MD:       DO:       PA:       NP:       Other: \_\_\_\_\_

▪ How many students could you accommodate per rotation? \_\_\_\_\_

▪ How often would you like a student?

Monthly       Quarterly       Bi-annually       Occasionally

▪ Have your patients and staff worked with students?    Yes       No

▪ What was their reaction? \_\_\_\_\_

▪ Would a student be permitted to examine patients in your practice under your supervision?

Yes       No

▪ Will you be able to assist with housing during the entire rotation?    Yes       No

▪ Please refer any colleagues who would also like to become a Preceptor: \_\_\_\_\_

***Thank you for your interest in joining our Preceptorship Program.***

***If you have any questions regarding this form please contact:***

Whitney Willis, Foothills AHEC Preceptor Coordinator

email: Whitney.Willis@nghs.com ▪ Foothills AHEC office: 770-533-6866

**Please return form to Foothills AHEC at your earliest convenience  
by fax: 770-533-9893 • email: whitney.willis@nghs.com  
or mail: 700 South Enota Drive, Suite 102, Gainesville, GA 30501**