New York University School of Medicine
550 First Avenue, New York, NY 10016

APPLICATION FOR INDIVIDUAL PRECEPTORSHIP FORM

GENERAL INFORMATION TO BE COMPLETED BY THE STUDENT

NAME:____ CLASS______________________

ADDRESS:____ TELEPHONE:________________

EXACT DATES OF ELECTIVE: __________________________

STUDENT'S SIGNATURE:___________________________ DATE:______________________

INFORMATION TO BE COMPLETED BY THE PRECEPTOR

NAME: (PRINT)____________________________ TELEPHONE____________

Hospital Affiliation:____

Departmental affiliation:____

Office Address:____

STUDENT'S RESPONSIBILITIES

Will there be patient contact?___________________________ If yes estimate hours spent in:

Private practice office hours:___________________________ Emergency Room: _____________

Hospitalized patients:_________________________________ Outpatient clinics:_______________

Other, please
specify:____

Total hours per week the student will spend on this elective: __________________

Please provide a detailed description of the student's daily activities below:

I agree to supervise the student above and provide an evaluation form at the conclusion of this elective.

____ ______________________________

Preceptor's signature/academic title

Approved: _____yes _____ no Number of weeks elective:__________

____ ______________________________

Associate Dean date