



APPLICATION FOR INDIVIDUAL PRECEPTORSHIP FORM

NOTE: Deadline for submission is two weeks prior to the elective beginning date in order to receive elective credit. Forms submitted after that date will not be eligible for credit. Preceptorships must have a minimum of 35hrs. per week in order to receive elective credit.

INFORMATION TO BE COMPLETED BY THE STUDENT

Name: _____

Class: _____

Address: _____

Tel: _____

Elective Title: _____

Exact Dates of Elective: From _____ To _____
(mm/dd/yyyy) (mm/dd/yyyy)

Student's Signature: _____

Date: _____
(mm/dd/yyyy)

INFORMATION TO BE COMPLETED BY THE PRECEPTOR

Name: _____

Tel: _____

Hospital Affiliation: _____

Departmental Affiliation: _____

Office Address: _____

STUDENT'S RESPONSIBILITIES

Will there be patient contact? Yes No

If Yes, please 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 for Curriculum

Date

PLEASE SUBMIT BY EMAIL, FAX OR IN-PERSON TO THE INFORMATION PROVIDED BELOW