Creighton UNIVERSITY
School of Medicine
Physician Assistant Program

Creighton University PA Program – Phoenix Preceptor and Site Profile Form

We appreciate your interest in partnering with the Creighton PA Program in Phoenix, Arizona. Please complete the following questions. Before submitting this application, please complete all fields. Missing information may require additional assistance to onboard the preceptor successfully.

Preceptor Name:

Preferred Salutation: Select

Preceptor License Type: Select ☐ Other:

If a PA, name of Supervising Physician:

License Information: State License #

Board Certification: Select

Which of the following best describes you? Select

Preceptor Preferred Email:

Preceptor Personal Phone Number:

Name of Practice/Group:

Name of Employer if different from practice name:

Type of Practice Setting: Select ☐ Other:

Practice Addresses (please list <u>all</u> if there are multiple locations you will take students):

1.

2.

3.

4.

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Who will be responsible for student scheduling with the PA Program? Select

☐ Other

Scheduling Contact's Name:

Scheduling Contact's Email:

Scheduling Contact's Primary Phone Number:

Scheduling Contact's Alternative Phone Number:

What is the best method for a student to contact their preceptor?

☐ **Contact the preceptor directly using the phone number and/or email provided**

☐ **Contact the Scheduling person using the phone number and/or email provided**

Practice Profile: Select

☐ **If Surgery:** Select

☐ Other:

Rotation Schedule/Hours:
Will the student be able to obtain an average of 36-40 hours of patient care per week? ☐ Yes ☐ No

Will the rotation include weekend hours? ☐ Yes ☐ No

Will the rotation include overnight shifts? ☐ Yes ☐ No

Will the rotation include being on call with the preceptor? ☐ Yes ☐ No

How many patients does the preceptor see during a typical shift?

How many patients will a student be expected to see during a typical shift?

Approximately what percentage of your patients are 0-18 years old?

Approximately what percentage of your patients are 19-64 years old?

Approximately what percentage of your patients are 65 years or older?

What is the rotation setting? Select

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Do you provide perioperative care? (Select all that apply)

- ☐ Pre-operative
- ☐ Intra-operative
- ☐ Post-operative
- ☐ N/A

Do you provide prenatal care to women? ☐ Yes ☐ No

Please check all activities the student will be able to perform while on this rotation:

- ☐ **History Taking**
- ☐ **Physical Examination**
- ☐ **Diagnostic Review & Interpretation**
- ☐ **Assessment / Plan of Care**
- ☐ **Patient Education / Counseling**
- ☐ **Assist with In-office Procedures**
- ☐ **Assist with Surgical Procedures**
- ☐ **Perform Patient Call Backs**
- ☐ **EMR Documentation**

Please list ALL facilities where you hold privileges and intend to have the student accompany you during the rotation (specific hospitals, surgery centers, etc.). This will allow the Program to ensure we have an affiliation agreement on file and credential the student(s) appropriately. ***If this should change throughout the year, please notify the Program immediately.***

Facility Address (name, street number, city, state, zip code):

1.
2.
3.
4.

Facility Contact Person for Student Credentialing e.g., Office of Graduate Medical Education, Medical Staff Services, etc. (name, phone number/email address):

1.
2.
3.
4.

Are there any site-related documents you want to provide the student/program? ☐ **Yes** ☐ **No**

If yes, please email documents, along with this completed form to maryannborgesen@creighton.edu