LE MOYNE COLLEGE PHYSICIAN ASSISTANT PROGRAM
NEW CLINICAL SITE REQUEST FORM

(315) 445-4745
(315) 445-4602 FAX

Date: _____

Student Name: _____

Type of Rotation: _____

Clinical Dates: _____

Preceptor Name and Title: _____

Preceptor Email Address: _____

Name of Practice: _____

Site Address: _____

City: _____State:_____ Zip:_____

Office Contact Person: _____

Office Phone:_____ Office Fax:_____

Practice Demographics: (Please list the average # of patients seen daily.) Daily Census: _____

Patient Population Distribution by Age:

Pediatrics (0 - 12): _____% Adults (18 - 64): _____%

Adolescents (13 - 17): _____% Geriatrics (65 & over): _____%

Percent of Preceptor's Time Spent in Settings Below:

Office: _____% Hospital: _____%

Clinic: _____% Nursing Home: _____%

If the student will be accompanying preceptor to a Hospitals or Surgery Centers, please list them below.

Site Name_____ Site Name_____

Address_____ Address_____

_____ _____

Tel. # _____ Tel. # _____

- Are there specific, date sensitive, requirements needing to be *completed by the PA Student* before starting a Clinical Rotation with your office and/or affiliated Hospital and/or Surgery Center, i.e. background checks, fingerprinting, PPD and physical, etc.? _____

  _____

  _____

- Are there any additional requirements that *the Le Moyne College PA Program must complete or fulfill* before our student begins a Clinical Rotation with your office and/or affiliated Hospital and/or Surgery Center, i.e. Affiliation Agreement, health forms, etc.? _____

  _____

  _____

- Does your practice require an Affiliation Agreement or Contract with Le Moyne College?

  _____Yes _____ No

  **If yes, would you accept Le Moyne College's contract for review? _____Yes _____ No

- Have you taken PA Students in the past? _____Yes _____ No
- Have you taken Medical Students in the past? _____Yes _____ No
- Would you be willing to precept more than one (1) Le Moyne College PA Student per year?

  _____ Yes _____ No

- Does your office employ PA's? _____Yes _____ No
- Does your office employ NP's? _____Yes _____ No

  **If so, will the PA Student work with him/her? _____Yes _____ No

- Are you able to provide a minimum of 36 hours per week of clinical time? _____Yes _____ No
- Will the PA Student be allowed to write in Charts and/or utilize the EMR to document in?

  _____Yes _____ No

- Will the PA Student be able to see the patient on their own prior to the office provider seeing the patient?

  _____Yes _____No

- Do you Take Call? _____Yes _____ No

**If so, will the PA Student be able to take call with you? _____Yes _____ No

- If you are a Women's Health provider, would you be willing to precept ***male*** PA Students?

  _____Yes _____No

- Do you recommend that the PA Student review any particular text/articles to help them be successful during their Clinical Rotation with you? _____

  _____

  _____

- Do you require that the PA Student complete a particular Clinical Rotation before doing a rotation with you, i.e.: General Surgery before Emergency Medicine? _____

  _____

- Is there housing available for students in your area? If so, please provide the contact information here:

Name and Office: _____

Phone Number: _____Email: _____

PLEASE ENCLOSE PRECEPTOR'S C.V. WITH THIS COMPLETED FORM

****IF YOU REQUIRE YOUR OWN AFFILIATION AGREEMENT, PLEASE SEND A COPY ALONG WITH THIS COMPLETED FORM****