Rural Physician Associate Program (RPAP)
Preceptor/Site Application Form
(Please type or print legibly . Use additional sheets as necessary)

Primary Preceptor Information

Name: Last, First, Middle Initial	**Previous Name**
Degrees (Check all that apply) ❒ MD ❒ DO ❒ MS ❒ MPH ❒ Other	**Spouse Name**
Day(s) that will NOT work for onsite educational visits ❒Mon ❒Tues ❒Wed ❒Thurs ❒Fri	**Usual day(s) & time off /week** ❒Mon ❒Tues ❒Wed ❒Thurs ❒Fri ❒AM ❒PM ❒Entire day ❒Varies
Interests/Hobbies	

Clinic Information *(Please include clinic brochure if available)*

Clinic Name	**Phone** ( )
Address	**Fax** ( )
City, State, Zip	**Total # of MD's** _____ FP _____ OB/GYN _____ Peds _____ General Surgery _____ General Internal Medicine _____ Other Surgical Specialty _____ Other Medicine Specialty
Manager/Administrator Name (❒MR ❒MS ❒MRS)	
Office space available for student ❒ Private ❒ Shared	

Hospital Information *(Please include hospital brochure if available and a list of attending/consulting physicians if available)*

Hospital Name	**Phone** ( )	**Fax** ( )
Address	**Number of** __________ Beds __________ ICU Beds __________ Admissions/year __________ Surgeries/year __________ Deliveries/year __________ Attending Staff __________ Consulting Staff	
City, State, Zip		
Manager/Administrator Name (❒MR ❒MS ❒MRS)		
Director of Nursing (❒MR ❒MS ❒MRS)		

General Surgeon	**Clinic**
Phone	**City/State**
Pediatrician	**Clinic**
Phone	**City/State**
General Internist	**Clinic**
Phone	**City/State**
Obstetrician/Gynecologist	**Clinic**
Phone	**City/State**

Nursing Home /Extended Care Facility Information

Name	Phone ( )	Fax ( )
Address		
City, State, Zip	___________ # of Beds	
Manager/Administrator Name	Director of Nursing (❒MR ❒MS ❒MRS):	

Minnesota Medical License #: ________________________________

Malpractice Insurance Carrier: ________________________________

Malpractice Insurance Policy #: ________________________________

Year Board Certified: ________________________________

Year Re-Certified: ________________________________

Please enclose copies of the following items to complete the application::

❒ Statement of support from hospital administrator
❒ Statement of support from nursing home/extended care facility director
❒ Statement of support from general surgeon
❒ Recent photograph

____ __________________________

Signature Date

Please return to: **Rural Physician Associate Program**
Mayo Mail Code 81, 420 Delaware St. SE
Minneapolis, MN 55455

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5/4/2005