

**University of New Mexico Physician Assistant Program
Preceptor/Site Questionnaire and Consent**

Primary Preceptor's Name: _____ Today's Date: _____

Practice/Site Name: _____

(Street Address)

(City)

(State)

(Zip)

Office #: _____ Cell #: _____ Fax #: _____

Email Address: _____ SSN (Required for Volunteer Faculty Appt): _____

Degree: MD DO PA NP RN Other: _____

Graduate School Attended: _____

Board Certification (Specialty): _____ Certification Expiration Date: _____

New Mexico Medical Board License #: _____ License Expiration Date: _____

Do you currently have an appointment with a UNM Department? Yes No (if YES, please specify below)

Which UNM Department established your appointment: _____

Volunteer Appointment or Paid Appointment Faculty or Staff UNM or UNMH

Practice Background – Please check all designations below which best describes the practice:

- | | | |
|--|--|--|
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Obstetrics and Gynecology | <input type="checkbox"/> Psychiatry/Neurology |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Orthopaedic Surgery | <input type="checkbox"/> Psychiatry/Neurology Subs: |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Pediatrics | _____ |
| <input type="checkbox"/> Family Medicine Subspecialty: | <input type="checkbox"/> Pediatrics Subspecialty: | <input type="checkbox"/> Surgery |
| _____ | <input type="checkbox"/> _____ | <input type="checkbox"/> Surgery Subspecialty: |
| <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Physical Medicine/Rehabilitation: | _____ |
| <input type="checkbox"/> Internal Medicine Subspecialty: | <input type="checkbox"/> Physical Med/Rehab Subspecialty: | <input type="checkbox"/> Women/Prenatal Health |
| _____ | _____ | <input type="checkbox"/> Clinic/Office-Based Setting |
| <input type="checkbox"/> Neurological Surgery | <input type="checkbox"/> Plastic Surgery | <input type="checkbox"/> In-Hospital Setting |

Hospital Affiliations (Name of Facility): _____

Practice Profile:

- | | | |
|---|--|---|
| <input type="checkbox"/> Department of Health | <input type="checkbox"/> Indian Health Service | <input type="checkbox"/> Veteran Medical Center |
| <input type="checkbox"/> Group Practice | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hospital-based | <input type="checkbox"/> Private Practice | _____ |

Office Personnel:

Please indicate the number of each personnel on site:

_____ MDs _____ PAs _____ RNs _____ NPs _____ OTs _____ PTs

_____ Community Health Worker _____ Health Educator/Public Health Professional

_____ Other Office Personnel (list): _____

Facilities on Site at Practice:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Clinical Lab | <input type="checkbox"/> Office Space for Student | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Internet Access | <input type="checkbox"/> On-Site Books/Journal References | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Other (describe): _____ | _____ | _____ |

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Additional clinical activities in which the preceptor or student may be involved:

- Community Healthcare Satellite Clinic Facilities: _____ Other: _____
 Hospital/Emergency Room Call _____
 Nursing Home/Hospice _____

Facility Designation:

- Health Professional Shortage Area Rural Area Other: _____

Student-related:

- Student Housing Provided Student Meals Provided
 Language Requirement? (specify) _____

Does the practice allow more than one student during the same clerkship? Yes No

If yes, what is the maximum number of students allowed? _____

Description of clinical skills and teaching available to students at the practice:

	Often	Occasionally	Seldom	N/A
Take patient histories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform physical examinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Formulate problem list, differential diagnoses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Formulate diagnostic and therapeutic plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discuss plan with patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Practice writing medication prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide patient education in health care maintenance, lifestyle modification, use of preventative healthcare guidelines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide patient education and counseling for coping with emotional issues of daily life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide patient education on normal growth and development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Provide patient education on advanced directives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform diagnostic and therapeutic procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make hospital rounds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make consultations with other healthcare professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate in teaching rounds, conferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Make visits to long-term care facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participate in community health/preventive programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opportunity to acquire of the business of healthcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opportunity to acquire understanding of community health issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opportunity for multicultural healthcare experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opportunity to work in rural or underserved area/population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Potential Patient Encounters and Populations (check all that apply):

Type of Patient Encounter:

- Acute
 Chronic
 Emergent
 Preventive
- Female
 Male

Age Group:

- Infant (0 – 12 months old)
 Children (1 – 12 years old)
 Adolescent (13 – 17 years old)
 Adult (18 – 64 years old)
 Elderly (65 years old and older)

Women's Health:

- General Gynecology
 Prenatal

Surgical:

- Intra-operative
 Post-operative
 Pre-operative

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Supplemental Information

Please provide a paragraph **describing** the activities you have been involved in during the past **two** years.

For example: Education and/or teaching; patient care, research, scholarship, creative activities; administration, other.
Please do NOT state "See CV". This information is required by Department Chairs and the School of Medicine Academic Affairs Office. Thank you!

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The undersigned hereby affirms as follows:

- 1) That the information (the "Information") furnished by me to the University of New Mexico (the "University") in connection with my Preceptorship application (the "Application") is true, correct, and complete to the best of my knowledge, information and belief after due investigation and diligence and is furnished to the University in good faith. I fully acknowledge and understand that the University is relying upon the accuracy and completeness of the information in considering the Application and, therefore, I acknowledge, understand, and agree that any material misstatement in or omission from the Application will constitute good and adequate cause for denial or revocation of Preceptorship status.

- 2) I further acknowledge and agree:
 - a. To assist, in every way possible, this School of Medicine program in gathering the information necessary to determine my qualifications for appointment. In this regard, I recognize that I have the burden of resolving any doubts about my qualifications for appointment.
 - b. In consideration for the acceptance of the Application, to release, acquit, and forever discharge any and all persons or entities that provide information, including but not limited to the Federation of State Medical Boards of the United States, Inc., the National Practitioner Data Bank, hospitals, licensure boards, of an from any claim, cause of action, liabilities, damages (including attorney's fees) to the fullest extent allowed by applicable statutes, regulations and judicial decisions arising out of or relating to the provisions of information to the University in connection with the Application. Furthermore, the undersigned does hereby release, acquit and forever discharge the University of New Mexico, its Health Sciences Center, the Medical Staff, its officers, employees and agents of and from any claim cause of action, liabilities, damages (including attorney's fees) arising out of or relation to any information or data concerning my performance as a member the Volunteer Clinical Staff at the University to third parties requesting the same in connection with provider credentialing at such Institution, health plan, or insurance provider or agents thereof.

- 3) I acknowledge and agree to the following preceptor responsibilities:
 - a. Assist the student in developing a plan that meets the student's personal professional objectives and program course objectives (to be provided by the program).
 - b. Assumes responsibility for determining which experiences are appropriate for student involvement.
 - c. Supervises the medical care provided by the student and other activities, as necessary to accomplish the objectives.
 - d. Maintains communication with the student and PA program faculty.
 - e. Provides guidance, feedback, and support to the student throughout their clerkship.
 - f. Participates with Physician Assistant program faculty and the student in the evaluation of the student's performance in the clinical setting.

Preceptor's Name (printed)

Preceptor's Signature

Date

Please return all four pages to: UNM Physician Assistant Program
1 University of New Mexico, MSC 09 5040
Albuquerque, NM 87131-0001
Theresa Crawford
(either by mail, email or fax) Fax: 505-272-9828
Email: TLMack@salud.unm.edu