

**PENNSYLVANIA
AHEC**

**PRECEPTOR PROFILE
P-1**

AHEC Region Use Only:

Preceptor ID: _____

The Pennsylvania AHEC is seeking to help meet the primary care needs of our communities and to make health careers training a more valuable experience. Results from this survey will be used to support these goals. All survey responses are confidential.

Date Completed: ____ / ____ / ____
Month Day Year

1. Your name: _____
Last Name

First Name

Middle Name

Credentials

2. What is the name of your primary practice site?

3. What is the address of your primary practice site?
Street Address _____
City _____ State _____
ZIP Code _____

4. What is your office phone number? (____) ____ - ____

5. What is your office fax number? (____) ____ - ____

6. What is your specialty? (check all that apply)

- Family Medicine
- General Internal Medicine
- General Pediatrics
- General Surgery
- OB/Gyn
- Physician Assistant
- Advanced Practice Nursing
- Psychiatry
- Pharmacy
- General Dentistry
- Allied Health
- Other _____

7. What degree have you received?

- MD
- DO
- PhD
- Master
- PharmD
- DPT
- DMD or DDS

Other _____

8. Are you Board Certified?

- Yes (1)
- No (2)

If Yes: Name of Certification _____

Begin Date _____ End Date _____

Name of Certification _____

Begin Date _____ End Date _____

9. Additional degrees earned (ex. Master of Business Admin, Master of Education, Master of Public Health).

10. Please provide the following information about your most recent precepting (teaching) experience.

School Affiliation _____

ZIP Code of Site _____

Type of student taught _____

Date completed _____
Month Year

11. What level and discipline of health professions student are you willing to mentor? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> First Year Medical Student | <input type="checkbox"/> Advanced Practice Nursing Student |
| <input type="checkbox"/> Second Year Medical Student | <input type="checkbox"/> Nursing Student |
| <input type="checkbox"/> Third Year Medical Student | <input type="checkbox"/> Dental Student |
| <input type="checkbox"/> Fourth Year Medical Student | <input type="checkbox"/> Pharmacy Resident |
| <input type="checkbox"/> Primary Care Resident | Other _____ |
| <input type="checkbox"/> Physician Assistant Student | |

10. How many students would you be willing to precept (teach) per academic year? ____

11. Please describe any additional preferences you have with respect to the students who may be placed with you?

AHEC Use Only:
Site ID1 _____
Site ID2 _____
Site ID3 _____

AHEC Use Only:
Date Entered: ____ / ____ / ____ Month Day Year
Entered by: _____