

**Bethel University Physician Assistant Program**  
**Preceptor & Site Profile**

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**Primary Preceptor:** \_\_\_\_\_ **Primary Email (required):** \_\_\_\_\_  
Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Primary specialty: \_\_\_\_\_ Secondary specialty: \_\_\_\_\_  
Medical License Number: \_\_\_\_\_ Issuing state: \_\_\_\_\_ Expiration date: \_\_\_\_\_  
Board Certified: \_\_\_\_\_ Board Eligible: \_\_\_\_\_ Date cert/recert: \_\_\_\_\_  
Professional/Medical school name: \_\_\_\_\_ Year graduated: \_\_\_\_\_  
Hospital affiliations: \_\_\_\_\_

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**Name of Practice/Facility:** \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Office phone: \_\_\_\_\_ Website: \_\_\_\_\_  
Clinic Manager: \_\_\_\_\_ Email &/or phone: \_\_\_\_\_  
Credentialing Personnel: \_\_\_\_\_ Email &/or phone: \_\_\_\_\_

Practice profile (check all that apply):

- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Solo practitioner              | <input type="checkbox"/> Inpatient only           | <input type="checkbox"/> Urban       |
| <input type="checkbox"/> Single specialty, independent  | <input type="checkbox"/> Outpatient only          | <input type="checkbox"/> Suburban    |
| <input type="checkbox"/> Single specialty, large system | <input type="checkbox"/> Inpatient/outpatient mix | <input type="checkbox"/> Rural       |
| <input type="checkbox"/> Multi-specialty, independent   | <input type="checkbox"/> Operating room           | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Multi-specialty, large system  | <input type="checkbox"/> Emergency room           | _____                                |

**If PA, Supervising Physician:**

Name: \_\_\_\_\_ State Lic. #/Exp: \_\_\_\_\_ Specialty Cert & Exp: \_\_\_\_\_

How many **students per rotation** are you able to accept? \_\_\_\_\_

How many **rotations per year** are you willing to participate in? \_\_\_\_\_

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Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to:**

[pa-clinical@bethel.edu](mailto:pa-clinical@bethel.edu)

Director of Clinical Education

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Phone: 651-635-8074 Fax: 651-287-0824

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