Bethel University Physician Assistant Program

Preceptor & Site Profile

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:_____

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):

___ Solo practitioner	___ Inpatient only	___ Urban
___ Single specialty, independent	___ Outpatient only	___ Suburban
___ Single specialty, large system	___ Inpatient/outpatient mix	___ Rural
___ Multi-specialty, independent	___ Operating room	___ Other_____
___ Multi-specialty, large system	___ 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? _____

Signature: _____ Title:_____

Printed name: _____ Date:_____

Return completed form to:
pa-clinical@bethel.edu
Director of Clinical Education
Bethel University * 3900 Bethel Drive * Bethel PA Program #2354 * Saint Paul, MN 55112-6999
Phone: 651-635-8074 Fax: 651-287-0824

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