University of North Texas Health Science Center
Physician Assistant Studies Program
Clinical Preceptor Profile

Name:	**Title: MD, DO, PA, NP (Circle one)**
Specialty:	**TX Medical Board License Number:**
Mailing Address:	**City, State, Zip:**
Phone:	**Fax:**
Email:	**Cell:**
Office Manager (or person to contact when scheduling a student):	
Office Manager Email:	
Office Manager Phone:	

Preferences:
How many PA students per 12-month period are you willing to precept each year? _____
(All rotations are 4 weeks in length)
Are there any months that you prefer to NOT to have a student? _____
If you request a particular student, please tell us the name of the student: _____
Other than English, what languages do you require students speak? _____

Credentialing: **Please list all facilities that students will need to be credentialed.**	**Estimated % of cases at each facility:**
Contact Name and Phone to credential at each facility:	

ABOUT YOUR PRACTICE:
Do you have any colleagues working with you that may be participating in the precepting of our students? If yes, please provide their name(s) and whether MD, DO, PA, or NP:
_____, _____, _____

Does your practice maintain professional liability insurance? (Circle one) Yes No

Please email or fax these documents to:
Director of Clinical Education
Fax: 817-735-2529

Approved: _____ Date: _____
Director of Clinical Education