Midwestern University Physician Assistant Program
19555 N. 59th Ave., Glendale, AZ 85308
Phone: (623) 572-3680 Fax: (623) 572-3227
email: azpaclinical@midwestern.edu

Preceptor & Site Profile Form 2025-2026

Preceptor Information (MD, DO, PA, NP)

Name and Credentials			
Are you Board Certified?	☐Yes ☐No ☐Board Eligible		
Area of Board Certification			
National Certifying Board			
Date certified **AND** re-certified (Mo/Yr)			
Practice Specialty			
Medical License	Number:	State:	Expiration Date:
Email address			
Preferred contact phone (for program use only)	☐cell ☐office		
Phone no. ***students*** may use to contact you.	☐cell ☐office		
If a PA, please provide the name of your primary supervising physician and their medical license number.			

Practice Contact Information

Practice/Group Name: (Contract Entity Name) Please Attach Certificate of Insurance, if available.		
Employer Name (if different from above):	☐Self-Employed ☐Employed by	
Main Office Address:		
Rotation Address: (If different from above)		
Contact Person/Office Manager: **For rotation scheduling*	Name:	
	Phone:	
	Fax:	Email:

Clinical Exposure **Appropriate breadth and depth of exposure on clinical rotations is supported by sufficient hours, adequate patient volume, and active hands on participation. **

1. Please indicate the number of hours/week in each setting, that the student will see patients.
   Outpatient Clinic ☐ Inpatient ☐ OR/Surgery ☐ ED ☐ Other ☐
2. Can the preceptor guarantee an average of 36 hours/week for duration of rotation period? ☐Y ☐N
3. Are there other clinicians within the group/practice that may train students in the preceptor's absence (i.e., vacation, conference, out of office)? ☐Y ☐N **If Yes, please provide name and attach certificate of insurance.**
   Name: ☐; Name: ☐
4. Approximately how many patients are seen daily? (Includes outpatient, inpatient, OR, etc.) ☐
5. Please select the activities that students will be allowed to observe/perform with supervision, during their time on rotation.

Activity	Observe	Perform
History Taking	☐	☐
Physical Examination	☐	☐
Diagnostic Interpretation	☐	☐
Assessment/Plan of Care	☐	☐
Patient Education/Counseling	☐	☐
Assist with in-office procedures	☐	☐
Assist with surgical procedures	☐	☐
Perform patient call-backs	☐	☐
EMR documentation	☐	☐
Rounds	☐	☐
Other*	☐	☐

Scheduling Information

Please indicate the TOTAL NUMBER of students you would like to train during EACH rotation block below. Should your availability change after this form has been submitted, please contact the program as soon as possible to avoid scheduling errors.

2025-2026 Rotation Block Schedule

Rotation Number	Start Date	End Date	Total number of students for this block
Rotation 1	5/27/25	7/2/25	
Rotation 2	7/7/25	8/12/25	
Rotation 3	8/18/25	9/25/25	
Rotation 4	9/29/25	11/4/25	
Rotation 5	11/10/25	12/18/25	
Rotation 6	1/5/26	2/10/26	
Rotation 7	2/16/26	3/26/26	
Rotation 8	3/30/26	5/6/26	

☐	I am unsure of my availability for 2025-2026; please contact me on an 'as-needed' basis for student placement (please check box).
	Is there a ***SPECIFIC STUDENT*** for whom you are providing this availability? If so, please provide their name.
☐	I am interested in precepting qualified students from other Midwestern Programs (Osteopathic Medicine, Podiatry).

Hospital Affiliations

To avoid scheduling/credentialing errors, please contact the program as soon as possible, if any changes in hospital affiliation, practice location, etc. occur after this form has been submitted.

Do you see or treat patients in a hospital or free-standing surgical center?	☐YES ☐NO

Please note: Accurate hospital/surgicenter information is critical for student credentialing and University/hospital affiliation agreement processing. Please list the facilities that you anticipate the student to attend so we may proceed with credentialing. Students will only be credentialed at a maximum of four hospital sites. ***Please list the four sites you attend most often. No student will be able to attend any facility that is not listed here, event in an observational capacity.***

	Facility Name and address	Hospital System Name	Are you an employee of this facility?	#days/wk you attend this facility	Name/ph # of hospital education coordinator
	eg. Tempe St. Luke's Hospital 1500 S. Mill Ave, Tempe, AZ	*Iasis Healthcare*	*No*	*2*	*Mary Smith, Med Staff Svcs 555-5555*
1					
2					
3					
4					

Thank you so much for providing this opportunity for our students. The Clinical Year faculty are here to support your educational efforts; please contact us any time with questions or concerns. Ph (623) 572-3680

Please email this form to: azpaclinical@midwestern.edu or please fax form to: (623) 572-3227

For Program Use Only:

Office Use Only:
Date: _____
_____Approved by CC.
Init._____
_____RMS
_____Typhon
_____Distance
Agmts. Initiated