Keck School of Medicine of USC

Division of Physician Assistant Studies
Primary Care Physician Assistant Program

OFFICE PRACTICE PROFILE

Site Name_____

MD/DO Preceptor's Name_____ **Email**_____

PA/NP/CNM Preceptor's Name_____ **Email**_____

Office Contact _____ **Email**_____

Street Address_____

City/State/Zip Code_____

Phone_____ **Fax**_____

Specialty:

☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ OB/GYN
☐ Orthopedics ☐ Emergency Medicine ☐ Mental Health ☐ General Surgery

Subspecialty _____ **Other** _____

1. Is the preceptor currently board certified?..... ☐ Yes ☐ No
2. Do you currently employ a Physician Assistant?..... ☐ Yes ☐ No
3. Has the preceptor ever been denied hospital privileges?..... ☐ Yes ☐ No
4. Has the preceptor ever had hospital privileges suspended or revoked?..... ☐ Yes ☐ No
5. Has the preceptor ever been placed on probation with regard to medical licensure?..... ☐ Yes ☐ No
6. Do you precept PA students from other programs?..... ☐ Yes ☐ No

   If yes, which programs? _____

Practice Type: ☐ Private ☐ Group

Special Site Designation (Please check all that apply):

____ HPSA
____ FQHC
____ FQHC Look-a-like
____ Rural Health Clinic
____ Tribal Health & Urban Indian program serving Federally Recognized tribes
____ Site run by and/or serving the Alaska Native populations
____ Indian Health Service site serving Federally Recognized tribes
____ Medically Underserved Area/Medically Underserved Population

Practice Setting (Please check all that apply):

____ Outpatient
____ Private-for-profit
____ College/University
____ Single-Specialty Group
____ Veterans Administration
____ Inpatient
____ Private-non-profit
____ Correctional Facility
____ Multi-Specialty Group
____ Other: _____
____ Nursing Home/SNF
____ Public
____ HMO
____ Military

Will the PA student accompany you to another site (hospital, nursing home, other practice)? ☐ Yes ☐ No

If yes, please provide the name and address of the site(s)_____

_____

Will other clinician (s) supervise the student? ☐ Yes ☐ No

If yes, please provide name(s) of the MD, DO, PA, NP, and/or CNM) who will supervise PA student on site.

Name _____ Title_____ License No._____☐ Always On-Site

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Name _____Title_____ License No._____☐ Always On-Site

Patient Information (Please indicate percentage for all that apply for a total of 100%):

Language(s) of Patients _____

Age range: ☐ < 2 yrs ☐ 2-4 yrs ☐ 5-12 yrs ☐ 13-17 yrs ☐ 18-49 yrs ☐ 50-64 yrs ☐ >=65 yrs

Patient Load**:** Outpatient___/week Inpatient_____/week

Type of Insurance (Please indicate percentage for all that apply for a total of 100%):

_____% HMO/Managed _____% Medi-Cal (Medicaid) _____% Medicare _____% PPO _____% Uninsured

For Office Use Only

On-Boarding Contact: Name: _____Email: _____

Notations: