University of Florida
Preceptor Information Form

Instructions: Complete all portions of the form applicable to your profession.

Date: _____

Last Name: _____ First Name: _____

Name of Practice: _____ Office Contact Person: _____

Primary Business Address: _____ City: _____ State: _____

Zip Code: _____ Office Telephone: (_____)_____ Fax: (_____)_____

Physician E-mail: _____ Office Contact E-mail: _____

Professional License #: _____

Professional Degree Program

Degree (e.g., MD, MSN, etc.)	Institution & Location	Year Graduated

Professional Designation: ☐ MD ☐ DO ☐ ARNP ☐ Dentist PA-C ☐ Other _____

Current Specialty: _____

University of Florida Faculty Member: ☐ Yes ☐ No

Hospital Privileges: ☐ Yes ☐ No Where:_____

_____

_____

In what type of community do you practice?

☐ Rural
☐ Inner-City Urban
☐ Urban (not inner-city)
☐ Suburban
☐ Other (please describe): _____

Will the student be permitted to interview and examine patients under your supervision?

In **office**: ◯ YES ◯ NO ◯ N/A In **hospital**: ◯ YES ◯ NO ◯ N/A

Will the student be allowed to accompany you in surgery? ◯ N/A ◯ NO ◯ YES: ☐ 1st assist ☐ 2nd assist

Signature: _____