Tulane University, School of Medicine
Department of Family and Community Medicine
1430 Tulane Avenue, #8033, New Orleans, Louisiana 70112-2699

Date Completed _____/_____/_____

PRECEPTOR INFORMATION FORM

FULL NAME: *(First, Last, Degree)*____

PRACTICE NAME: ____

Street Address ____

City ______________________ State_________ Zip Code__________ Parish_____________

Phone (_______)______________________ Fax (_______)______________________

Office Contact ______________________ Contact's Number (_______)__________________

Email Address ________________@______________.___________ Home Office

Your Partners ____

PRACTICE TYPE: Solo Group (single/multi specialty: ____________) Residency HMO

SUPPORT STAFF: Front Office (_____)__________________ Back Office (_____)__________________

PRACTICE POPULATION: *(Check All That Apply)* Urban Suburban Rural Largely Underserved Patients

NUMBER OF PATIENTS SEEN: *(Specify Monthly or Annually)* ______________________________

DIVERSITY OF PATIENT POPULATION: ______% Pediatrics ______% Adult ______% Geriatric

DO YOU MAKE HOSPITAL ROUNDS/CARE FOR YOUR OWN INPATIENTS: Yes No

PRECEPTOR INFORMATION: SS # _______-_____-_______ Birthdate ______/______/______

(Required For Clinical Faculty Appointment)

PRIOR TEACHING EXPERIENCE:

Required 3rd Year Clerkship 4th Year Preceptorship Summer Preceptorship (1 month) Other

PROFESSIONAL CERTIFICATION

Your Medical School/Graduate School____

Graduation Year____________________ Residency________________________________

Are you Board Certified in Family Medicine? Yes No Year Last Certified___________

HOSPITAL AFFILIATION(S): ____

____

LIST SPECIAL INTERESTS/PROCEDURES AT SITE: ______________________________

____

COMPUTER INFORMATION:

Internet access at the office? Yes No Internet access available to students? Yes No

STUDENTS WITH YOU WILL HAVE A SUBSTANTIAL CLINICAL EXPERIENCE WITH:

Patients who have significant barriers in accessing health care. Yes No

Patients from an economically struggling region. Yes No

Patients at increased risk for illness because of *(Check All That Apply; Make Comments on the Back, but FAX Both Sides!)*

Age (Elderly)	Disability	HIV positive
Chronic medical conditions	Economically disadvantaged	Substance abuse
Ethnically diverse population	Homeless	Survivors of incest or violence

PLEASE RETURN TO THE ABOVE ADDRESS OR FAX BACK TO 504-988-4701 Attn: Adam