

CBSE Site Form

Clinical Site Information

Site Name:				
Site Contact:			Phone Number:	
Site Address:			Email Address:	
No. of Physicians:	No. of PA's:	No. of NPs:	No. of exam rooms:	Avg. No. of daily patients

Populations Served (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> Older Adults (55+) |
| <input type="checkbox"/> Children | <input type="checkbox"/> People with disabilities |
| <input type="checkbox"/> College Students | <input type="checkbox"/> Pregnant Women and Infants |
| <input type="checkbox"/> Health Insurance Marketplace eligible individuals | <input type="checkbox"/> Returning war veterans |
| <input type="checkbox"/> Individuals with HIV/AIDS | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Migrant Workers | <input type="checkbox"/> Victims of abuse or trauma |
| <input type="checkbox"/> Military and/or military families | <input type="checkbox"/> Other (<i>please specify</i>): |

Site Type (Select all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Provider office- Primary Care | <input type="checkbox"/> Other Ambulatory Practice Site |
| <input type="checkbox"/> Provider office- Specialty | <input type="checkbox"/> Community Hospital |
| <input type="checkbox"/> FQHC | <input type="checkbox"/> State Hospital |
| <input type="checkbox"/> FQHC look-alike | <input type="checkbox"/> Tertiary Care Referral Hospital |
| <input type="checkbox"/> Rural Health Clinic | <input type="checkbox"/> Surgery Center |
| <input type="checkbox"/> Public Health Clinic | <input type="checkbox"/> Tribal Hospital |
| <input type="checkbox"/> Correctional Health Clinic | <input type="checkbox"/> Armed Forces Hospital |
| <input type="checkbox"/> Tribal Health Clinic | <input type="checkbox"/> Veteran's Hospital |
| <input type="checkbox"/> VA Health Clinic | <input type="checkbox"/> Correctional Health Hospital |
| <input type="checkbox"/> Armed Forces Health Clinic | <input type="checkbox"/> Long Term Care Facility |
| <input type="checkbox"/> Community Safety- Net Health Clinic | <input type="checkbox"/> Rehabilitation Facility |
| <input type="checkbox"/> Behavioral Health Clinic | <input type="checkbox"/> Behavioral Health Facility |
| <input type="checkbox"/> Hospice Service | <input type="checkbox"/> Other Institutional Site |
| <input type="checkbox"/> Homecare Service | |

²⁰ Which Disciplines are trained at this site (Select all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Student—CNS | <input type="checkbox"/> Student—Pharmacy School |
| <input type="checkbox"/> Student—NP | <input type="checkbox"/> Student—Physical Therapy |
| <input type="checkbox"/> Student—Dentistry | <input type="checkbox"/> Student—Physician Assistant |
| <input type="checkbox"/> Student—Medical School | <input type="checkbox"/> Student—Podiatry School |
| <input type="checkbox"/> Student—Chiropractic School | <input type="checkbox"/> Student—Nursing |
| <input type="checkbox"/> Student—Occupational Therapy | <input type="checkbox"/> Student—Speech Therapy |
| <input type="checkbox"/> Student—Optometry | |

Preceptor Information

Name:		Phone Number:	
Address:		Email Address:	
Discipline:			
<input type="checkbox"/> Allopathic Medicine	<input type="checkbox"/> Community Health Worker	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Dental Assistant
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Behavioral Health Sciences	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Dental Hygiene
<input type="checkbox"/> Osteopathic Medicine	<input type="checkbox"/> Health Services	<input type="checkbox"/> Registered Nurse	<input type="checkbox"/> Dentistry
<input type="checkbox"/> Optometry	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Clinical Lab Worker	<input type="checkbox"/> Clinical Psychology
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Public Health	<input type="checkbox"/> EMT/Paramedic	<input type="checkbox"/> Clinical Social Work
<input type="checkbox"/> Podiatry	<input type="checkbox"/> Veterinary Medicine	<input type="checkbox"/> Data Analysis	<input type="checkbox"/> Counseling/ Substance Abuse
<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Other (<i>please specify</i>):
	<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Physical Therapy	
Specialty (<i>please specify</i>):			
Currently serving as a preceptor: <input type="checkbox"/> Yes <input type="checkbox"/> No	Interested in serving as a preceptor: <input type="checkbox"/> Yes <input type="checkbox"/> No	Interested in SEAAHEC offered CMEs: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical/Professional School Name:		Date Graduated:	
Board Certified <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital Affiliations/ Privileges: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes specify:		

I am willing to work with the following students: <input type="checkbox"/> High School Students (<i>shadowing only</i>) <input type="checkbox"/> Undergraduate Students (<i>shadowing only</i>) <input type="checkbox"/> Graduate Students <input type="checkbox"/> Health Professions Students (NP, PA, Dental, etc.) <input type="checkbox"/> Medical Residents <input type="checkbox"/> All of the above <input type="checkbox"/> Other (<i>please specify</i>):	Office Hours: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:				
Length and Frequency Willing to Serve as Preceptor					
	Daily	Weekly	Bi-weekly	Monthly	Open to Any Timeframe
3-4 Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5-6 Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-8 Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> 8 Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (<i>please specify</i>):					

Last Revised 10/2015