



Form B

PRECEPTOR AND SITE PARTICIPATION

AHEC is required to report general demographic information about participants in the categories below. This data will be confidentially maintained and will be referenced periodically to evaluate the effectiveness of AHEC services and programs. We appreciate your cooperation in the completion of this form. Please type or print clearly.

SITE INFORMATION

Name of Practice/Site:

Street Address:

City:

State:

Zip code:

Site Contact Person:

Title:

Site Phone:

Site Fax:

Program Site Designated Area:

- HPSA 50% Medicare/Medicaid Other Medically Underserved Area
 Urban Area with 50%+ Medicaid or Uninsured Not a Medically Underserved Area

National Health Service Corps (NHSC) Site:

- Yes _____ Number of current vacancies
 No

Site Designation: (Check all that apply):

- Community Health Center Federally Qualified Health Center National Health Service Center or Tribal Health Site
 Migrant Health Center Private Practice Governor Designated Area Ambulatory Practice Site
 Healthcare for the Homeless Health Department Other _____
 Public Housing Primary Care Urban Clinic
 Rural Health Clinic Federal Designated Health Profession Shortage Area
 Academic Practice Hospital (Name) _____

#1 PRECEPTOR INFORMATION

- Mr. Mrs.
 Ms. Dr.

Name (Last, First, MI):

Suffix or Credential:

Street Address:

City:

State:

Zip code:

Discipline (choose one category):

- Administrator Nurse Practitioner Pharmacy Radiation Technician
 Community Health Worker Nurse – Registered Physical Therapy Speech Therapy
 Dental Hygienist Nurse – Bachelors Degree Physician - Allopathic Social Work/Mental Health
 Dietary/Dietetics Nurse – Other Physician - Osteopathic Other _____
 Emergency Medical Technician Occupational Therapy Physician Assistant
 Licensed Practical Nurse Paramedic Public Health

Race/Ethnicity (check one):

- American Indian or Alaskan Native Hispanic or Latino
 Asian: underrepresented (i.e., Cambodia, Malaysia, Pakistan, Vietnam) Native Hawaiian or Other Pacific Islander
 Asian: Non-underrepresented (i.e., China, Philippine, Japan, Korea, India, Thailand) White– Non Disadvantaged
 Black or African American White – Disadvantaged
 More Than One Race
- Male
 Female

Health professional student discipline of study for which you are willing to provide training (choose one category):

- Administration Medicine-Osteopathic Nurse –Practitioner Physical Therapy Undergraduate Nursing
 Dentistry Student Nurse Midwife PT Assistant LPN
 Dietary/Dietetics Resident Occupational Therapy Radiology Technician RN
 EMS/EMT Mental Health OT Assistant Respiratory Therapy Other Area of Study _____
 Medicine-Allopathic Nurse Anesthetists Pharmacy RT Assistant
 Student Nursing Assistant Physician Assistant Social Work
 Resident Nurse – RN Public Health Speech Therapy

#2 PRECEPTOR INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	Name (Last, First, MI):	Suffix or Credential:		
Street Address:	City:	State:	Zip code:	
Discipline (choose one category):				
<input type="checkbox"/> Administrator	<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Radiation Technician	
<input type="checkbox"/> Community Health Worker	<input type="checkbox"/> Nurse – Registered	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Speech Therapy	
<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Nurse – Bachelors Degree	<input type="checkbox"/> Physician - Allopathic	<input type="checkbox"/> Social Work/Mental Health	
<input type="checkbox"/> Dietary/Dietetics	<input type="checkbox"/> Nurse – Other	<input type="checkbox"/> Physician - Osteopathic	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Emergency Medical Technician	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician Assistant		
<input type="checkbox"/> Licensed Practical Nurse	<input type="checkbox"/> Paramedic	<input type="checkbox"/> Public Health		
Race/Ethnicity (check one):			<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Hispanic or Latino		
<input type="checkbox"/> Asian: underrepresented (i.e., Cambodia, Malaysia, Pakistan, Vietnam)		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		
<input type="checkbox"/> Asian: Non-underrepresented (i.e., China, Philippine, Japan, Korea, India, Thailand)		<input type="checkbox"/> White– Non Disadvantaged		
<input type="checkbox"/> Black or African American		<input type="checkbox"/> White – Disadvantaged		
<input type="checkbox"/> More Than One Race				
Health professional student discipline of study for which you are willing to provide training (choose one category):				
<input type="checkbox"/> Administration	<input type="checkbox"/> Medicine-Osteopathic	<input type="checkbox"/> Nurse –Practitioner	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Undergraduate Nursing
<input type="checkbox"/> Dentistry	<input type="checkbox"/> <i>Student</i>	<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> PT Assistant	<input type="checkbox"/> LPN
<input type="checkbox"/> Dietary/Dietetics	<input type="checkbox"/> <i>Resident</i>	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Radiology Technician	<input type="checkbox"/> RN
<input type="checkbox"/> EMS/EMT	<input type="checkbox"/> Mental Health	<input type="checkbox"/> OT Assistant	<input type="checkbox"/> Respiratory Therapy	<input type="checkbox"/> Other Area of Study _____
<input type="checkbox"/> Medicine-Allopathic	<input type="checkbox"/> Nurse Anesthetists	<input type="checkbox"/> Pharmacy	<input type="checkbox"/> RT Assistant	
<input type="checkbox"/> <i>Student</i>	<input type="checkbox"/> Nursing Assistant	<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Social Work	
<input type="checkbox"/> <i>Resident</i>	<input type="checkbox"/> Nurse – RN	<input type="checkbox"/> Public Health	<input type="checkbox"/> Speech Therapy	
FOR OFFICE USE ONLY				
Site Type:				
<input type="checkbox"/> Preceptor Site	<input type="checkbox"/> Clinic	<input type="checkbox"/> Hospital	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Other _____
Designated Area:				
<input type="checkbox"/> HPSA	<input type="checkbox"/> 50% Medicare/Medicaid	<input type="checkbox"/> Other Medically Underserved Area	<input type="checkbox"/> Urban Area with 50%+ Medicaid or Uninsured	
<input type="checkbox"/> Not a Medically Underserved Area				
Reviewing AHEC Staff Member:			Date:	
Data Entry:			Date:	