ELIZABETHTOWN COLLEGE PHYSICIAN ASSISTANT PROGRAM

Supervised Clinical Practice Experience: Letter of Intent

Preceptor **(B3.01)**

Health Care Facility Name: _____

Address: _____

Preceptor Name/Title: _____

Email: _____ Phone Number: _____ Fax Number: _____

Discipline: [ ] Family Medicine [ ] Pediatrics [ ] Women's Health

[ ] Surgery [ ] Internal Medicine [ ] Emergency Medicine

[ ] Behavioral/Psychiatric Medicine [ ] Other _____

For each of the following 5-week supervised clinical practice experiences, please indicate the number of students you are tentatively willing to accommodate beginning August 2023.

Tentative Rotation Dates	Number of Students	Notes
1: August-September		
2: October-November		
3: November-December		
4: January-February		
5: February-March		
6: April-May		
7: May-June		
8: July-August		

Preceptor Name/Credentials:

Name:_____ License Number: _____ Board Certified [ ]

Supervising or Collaborating Physician Name/Credentials:

Name:_____ License Number: _____ Board Certified [ ]

Completion of the above signifies the preceptor's intent to support the Clinical Education of students enrolled in Elizabethtown College's Physician Assistant Program.

_____ _____

Signature of Preceptor Date

_____ _____

Elizabethtown College PA Program Representative Date

[ ] Affiliation Agreement Signed