

PRECEPTOR APPROVAL PROCESS

The approval process begins with completion of the *Preceptor Pre-Approval Form* by the Preceptor, Assistant Preceptor or Facilities Manager.

The *Preceptor Pre-Approval Form* is designed for gathering information on sites where the student will be observing, experiencing “hands-on” training in primary care, or completing hospital and ER rotations. It is also designed to ensure that Assistant Preceptors, if utilized, clearly designate the physician who is ultimately responsible for the student’s clinical activities.

Not every clinician who has casual teaching contact with the student needs to fill out the form. For example, if a student is training in a multi-specialty group whose several physicians are covered by one facility agreement with Stanford University, the student shall complete the *Preceptor Pre-Approval Form* only for a clinician who provides more than nine (9) days total of clinical supervision. This training must be in the same facility as his/her Primary Preceptor, and with the Preceptor’s knowledge and agreement. The student chart notes must be signed by the physician who provided the training, and it is recommended that the student discuss that work with the Precepting physician as well. If the training exceeds nine days, the student needs to have that physician complete the form as a Supplemental Preceptor.

If there is no broad facilities agreement with Stanford University, the student must treat each physician and site as a Supplemental Preceptor and complete the form. For example, if an office building has five physicians who are all independent practitioners, the Primary Preceptor may not send the student down the hall to train with his colleague unless that physician has first been approved as a Supplemental Preceptor.

Each facility may have rules that govern student activities. Section 2 on the *Preceptor Pre-Approval Form* asks for information on facility contacts. This will most often be required of large facilities such as County health clinics, multi-specialty groups, skilled nursing facilities, or hospitals where students are doing inpatient, surgery or emergency room rotations.

Note: A Primary Preceptor who has hospital privileges may invite a student to observe inpatient hospital rounds or operating room procedures. Even though no patient contact is planned facilities often have strict rules regarding clearance for those observing activities. Often the Primary Preceptor is not aware of the facility policy regarding students. It is the student’s responsibility to ask the facilities manager if any special clearances are required, and should complete Section 2 for any facility that needs confirmation of student clearance.

Attached is a description of the approval process and the 5 page pre-approval form. The form may be copied as needed. Once the form has been submitted to PCAP allow 2 weeks for processing. If a new facilities agreement and contract needs to be developed please allow 6 weeks. Once approved, the Preceptor Coordinator will send written confirmation of approval and a statement regarding malpractice coverage.

The information gathered will be maintained in a PCAP database and updated annually.

APPROVAL RESPONSIBILITIES

Students will

- Read the Preceptor Manual in order to understand the type of medical settings and medical providers that are appropriate and qualified to provide preceptorships
- Seek settings and medical providers with qualities and requirements outlined in the Preceptor Manual.
- Discuss with their Faculty Advisor the names of medical providers the student would like to contact.
- With Faculty Advisor approval contact individual medical providers and describe the preceptor role
- Provide a copy of the Preceptor Manual to medical providers who are interested in precepting a student
- Make earnest effort to acquire a Primary Preceptor before the start of classes in September
- Maintain regular contact with their Faculty Advisor regarding the progress of their efforts to find a Primary Preceptor. The Faculty Advisor will help problem-solve if a student has difficulty finding preceptors

Medical Providers who are interested in serving as preceptors will

- Read the Preceptor Manual in order to understand the type of medical settings and medical providers that are appropriate and qualified to provide preceptorships
- Provide all information requested on the *Preceptor Pre-Approval Form*
- Mail and/or fax the original *Preceptor Pre-Approval Form* with original signature to

Faculty Advisor
c/o Monique Rodriguez
1215 Welch Road, Modular G
Palo Alto, CA 94305-5508
moniquer@stanford.edu
fax: (650) 723-9692

PCAP staff and Faculty Advisor will

- Evaluate and verify information provided on the Pre-Approval Form
- Decide within two weeks of receipt of information whether the preceptor is approved
- Send confirmation letters to approved preceptors

The Faculty Advisor will

- Notify the student of the results of the approval process
- Coordinate the student's clinical plans once the preceptorship has been approved
- Coordinate the response to the medical provider who has NOT been approved for preceptorship and work to correct minor deficiencies
- Develop strategies for seeking another qualified Preceptor should the deficiencies be insurmountable

The Site Visitor will

- Approve preceptors/sites/timing of supplementary preceptorships and rotations after January
- Communicate clinical plans with the student's Faculty Advisor

Primary Care Associate Program
Stanford University School of Medicine

PRECEPTOR PRE-APPROVAL FORM

- Primary Preceptor:** MD or DO who will take responsibility for the majority of the student's clinical instruction AND whose practice is in primary care medicine.
- Supplemental Preceptor:** MD or DO whose practice supplies required learning experiences that are not sufficiently provided by the Primary Preceptor. Example: Pediatrics, women's health.
- Assistant Preceptor:** PA, NP, CNM or other licensed professional, working under the supervision of an MD/DO, who provides important, regular and recurring training of the student in primary care. Every Assistant Preceptor must be accompanied by the name of an MD or DO who will agree to supervise the student's training.
- Facility** (check if the student will be precepting at a facility such as multi-specialty clinic, hospital, etc. See Section 2 below)

| | |
|-------------------------------------|------------------------|
| Student Name | Faculty Advisor |
| Desired Clinic/Rotation start date: | Site Visitor |

1. Preceptor Information

| | | | | |
|---|---|--|--------------------------------------|---------------------------------------|
| Preceptor Name | <input type="checkbox"/> MD / DO | <input type="checkbox"/> primary | <input type="checkbox"/> NP | <input type="checkbox"/> supplemental |
| | <input type="checkbox"/> PA | <input type="checkbox"/> asst. preceptor | <input type="checkbox"/> Other | |
| California License #: | | Expiration date: | | |
| Clinic Name | | | | |
| Street Address | | | | |
| City: | | County: | | State/Zip: |
| Tel: | Fax: | Cell: | Email: | |
| Practice Specialty: | <input type="checkbox"/> General Practice | <input type="checkbox"/> Family Practice | <input type="checkbox"/> Pediatrics | |
| | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Urgent Care | |
| | <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Orthopedics | <input type="checkbox"/> ER | |
| | <input type="checkbox"/> Surgery | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Other | |
| Current Hospital Staff Privileges | | Location (City) | | Hospital Staff Status |
| facility | | | | |
| facility | | | | |
| Precepting Experience: | | | | |
| Have you previously precepted a PCAP student? | | | | |
| | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| If "yes" please provide student name: | | | | |

2. Facility Information

Complete this section if the student will be in a facility that has an office that coordinates training or requires a facility contract to be in place. Fill out this section for hospital and emergency room rotations.

Facility Name

Street Address

City

County

State/Zip

Facility/Clinic Manager
 Human Resources
 Education Department
 Medical Staffing Office
 Nursing Administration
 Contracting Department
 Other (describe)

Contact Name:

Tel:

Fax:

Cell:

Email:

Does your facility require a contract?
Is one in place?

Yes
 Yes

No
 No

If yes, indicate the date contract expires:

3. Insurance Information

Has your medical license ever been revoked, suspended or limited in any manner?

Yes*

No

Have you been party to a malpractice action during the past five years?

Yes*

No

Have your hospital privileges ever been suspended, revoked, restricted, or not renewed?

Yes*

No

***If you answered YES to any of the above questions an explanation MUST be submitted with this application. We will verify all professional credentials with the appropriate state licensing Board.**

Provide the full name of your malpractice insurance carrier and amount of coverage:

4. Practice Information & Demographics

Community Size:

population < 4,220
 (exceptionally rural)
 Other (describe)

population < 6,995
 (mid-rural)

population < 13,600
 (rural)

Estimate the percentage of patient population seen at your facility for each of the following categories:

Medicare %

Medi-Cal %

Medically Indigent %
(receive services at no charge)

Describe any special demographic or ethnic population for which you provide services, including percent of your practice for each group.

Primary language(s) of clinic population:

List special language skills *required* of your clinicians:

| | | | |
|---|---|---|--|
| Type of practice | | | |
| Check ONE that best describes your practice: | <input type="checkbox"/> HMO | <input type="checkbox"/> Private solo practice | <input type="checkbox"/> Hospital-based clinic |
| | <input type="checkbox"/> Managed Care Organization | <input type="checkbox"/> Private group practice | <input type="checkbox"/> Military clinic |
| | <input type="checkbox"/> Other | | |
| Underserved type Check ALL that describe your practice service, location or patient population | | | |
| <input type="checkbox"/> AUN -Area of unmet need | <input type="checkbox"/> MHC -Migrant Health Center | | |
| <input type="checkbox"/> CC -CA licensed Community Clinic | <input type="checkbox"/> MUA -Medically underserved area | | |
| <input type="checkbox"/> CHC -Bureau of Primary Health Care Community Health Center | <input type="checkbox"/> MUP -Medically underserved population | | |
| <input type="checkbox"/> CNTY -County Public Health Facility or Jail | <input type="checkbox"/> NHSC -National Health Service Corps | | |
| <input type="checkbox"/> FC -CA licensed Free Clinic | <input type="checkbox"/> PHPC -Public Housing Primary Care | | |
| <input type="checkbox"/> FQHC -Federally Qualified Health Center | <input type="checkbox"/> RHC -Rural Health Center | | |
| <input type="checkbox"/> FQHC-LA Federally Qualified Health Center Look Alike | <input type="checkbox"/> TRHP -Tribally Run Indian Health Services Program | | |
| <input type="checkbox"/> HO -Health Care for Homeless | <input type="checkbox"/> UIHC -Urban Indian Health Center | | |
| <input type="checkbox"/> HPSA -Health Professional Shortage Area | <i>Note: PCAP staff will confirm the accuracy of this information</i> | | |

5. Work Hours and Facility Information

| | |
|---|--|
| Avg. # of outpatients you see per day in clinic | _____ |
| Avg. # of inpatients you see per day in hospital | _____ |
| Avg. # of patients you see per day in nursing home | _____ |
| Hours per week you work in the following: | |
| Office/clinic: | _____ |
| Hospital: | _____ |
| Nursing home/SNF: | _____ |
| Other: | _____ |
| Total hours per week: | _____ |
| # of exam rooms available to you on days when this student will be in the office | _____ |
| Can a student occupy an exam room continuously for up to 7-8 hours on preceptorship days? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "No", for how many hours will the student be able to utilize an exam room on preceptorship days? | # hours _____ |
| Will the student be able to write notes in clinic charts? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dictate? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Make entries in electronic records? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If you are a PA, NP or CNM hoping to serve as an Assistant Preceptor have you made arrangements for MD/DO supervision? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" please list the name(s) and license # of the MD/DO who will assume ultimate responsibility for the student being trained by an Assistant Preceptor AND make sure physician signature appears in Section 6. | _____ |
| Does the facility have an office laboratory available for training the student in performing wet mounts, urinalysis, hemoglobin/hematocrit, etc? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

6. Signatures

If approved to serve as Preceptor Assistant Preceptor (check one) I agree to

- provide student training and supervision in accordance with California State Law
- provide for a variety of patient encounters necessary for an appropriate learning experience
- review regularly the student's objectives to identify the focus of his/her studies and assure that the clinical experience meets the student's learning goals
- provide the agreed upon hours of experience required for the student's training
- be on site during the student's hours for supervision, consultation and teaching
- ensure that the student does not practice beyond his/her competency or legal authority
- review and countersign every student medical record within 24 hours; if Assistant Preceptor, also ensure that the supervising physician reviews and countersigns within 7 days
- provide feedback to the student and Program regarding student performance; this includes quarterly written evaluations and/or end-of-rotation evaluations
- notify the student's Faculty Advisor and Site Visitor at the earliest sign of a problem to assure timely resolution
- acknowledge that the student will be providing PCAP with a written evaluation of the preceptorship at the end of the preceptorship or rotation

Signature

- MD / DO
 NP
 PA
 Other

- Primary
 Supplemental
 Asst. Preceptor

Print Name

Date

Attention Physicians who have agreed to serve as the ultimate supervisor of an Assistant Preceptor: Your signature below is **required** and indicates that you have read the information provided on this form and acknowledge you assume ultimate responsibility for the student being trained by an Assistant Preceptor. Attach additional sheets if more than one physician will be supervising the Assistant Preceptor.

Supervisor of Asst. Preceptor

License #

Date

Approved by:

Faculty Advisor

Date

Site Visitor

Date

PCAP

Date

Stanford University/Foothill College Primary Care Associate Program
 Family and Community Medicine
 Stanford University
 1215 Welch Road, Modular G
 Palo Alto, CA 94305-5408
 (650)723-6432

INFORMATION RELEASE AUTHORIZATION

For purposes of my participation in the Primary Care Associate Program I understand that PCAP must verify my professional training, experience and conduct. My signature below authorizes representatives of the Primary Care Associate Program at Stanford School of Medicine to contact individuals, agencies and hospitals which have been named in this document, as well as medical staff, medical schools, hospitals or medical centers, training programs, medical societies, professional associations, professional liability insurance companies and licensing authorities, in jurisdictions in which I have trained, resided or practiced, for the evaluation of my professional competence, experience, character and good judgment. I consent to the communication of information and documents between PCAP and the agents/agencies listed above.

I agree to release Foothill College, Stanford University School of Medicine and the Primary Care Associate Program from civil liability regarding processing of my approval form. I release from liability any and all individuals and organizations who provide information to PCAP in good faith without malice concerning my professional competence, ethics, character and other qualifications to be a clinical preceptor in the Primary Care Associate Program.

I hereby affirm that the information furnished by me is true to the best of my knowledge and is furnished in good faith.

| | | |
|----------------------------|--|---|
| Preceptor Signature | <input type="checkbox"/> MD / DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> Other | <input type="checkbox"/> Primary <input type="checkbox"/> Supplemental <input type="checkbox"/> Asst. Preceptor |
|----------------------------|--|---|

| | | |
|------------|-----------|------|
| Print Name | License # | Date |
|------------|-----------|------|

Attention Physicians who have agreed to serve as the ultimate supervisor of an Assistant Preceptor: Your signature below is **required** and indicates that you authorize information release as needed in order to be approved as supervisor of an Assistant Preceptor. Attach additional sheets if more than one physician will be supervising the Assistant Preceptor.

| | | |
|-------------------------------|-----------|------|
| Supervisor of Asst. Preceptor | License # | Date |
|-------------------------------|-----------|------|

For Facility office Reply

Privileges at:

Attention Hospital Credentialing Department:

Please advise as to the current status of the above named medical provider. A preaddressed stamped envelope is enclosed for your convenience. Thank you for your prompt reply.

- Active**

 Associate

 Courtesy

 None
 Other

Verified by: