IAFP FOUNDATION 2009 SUMMER EXTERNSHIP PROGRAM
PRECEPTOR PARTICIPATION FORM

Preceptor Name: _____

Clinic Name: _____

Office Address: _____

City/State/Zip: _____

Phone Number: _____ Fax #: _____

E-mail Address: _____

1. Please indicate your availability in hosting a medical student:

   a) I can host a maximum of ____ student(s) during the summer of 2009.

   b) I can host students between _____ and _____ (give dates).

   c) I can host a medical student at any time **EXCEPT** as noted: _____

   _____

2. Are you able to provide room and board for a student, either through personal means or through your hospital? Yes No
   If yes, please explain arrangements and any restrictions: _____
   _____
   _____

3. Would your site benefit by having a student who is fluent in a foreign language?
   Yes No
   If yes, please indicate which language: _____

4. Will your extern be exposed to:

Sub-specialists to whom you refer patients?	Yes	No
Mid-level providers (PAs/NPs/etc.)?	Yes	No
Nursing home and/or hospice personnel?	Yes	No
Obstetrics/deliveries?	Yes	No
Geriatrics?	Yes	No

5. Who is your malpractice insurance carrier? _____

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As a preceptor for the IAFP Foundation Summer Externship Program, I agree to assume responsibility for the work schedule of the student(s) assigned to my site.

_____ _____

Signature Date

Preceptors will be notified by April 30th of the student assignments and externship dates. Questions??? Contact Crishelle at 630-427-8006 or via e-mail at corourke@iafp.com.

Please return this application to: Illinois Academy of Family Physicians Foundation, Summer Externship Program, 4756 Main Street, Lisle, Ill. 60532, or fax: 630-435-0433.