SUMMER 2017 PRECEPTORSHIP PROGRAM
APPLICATION FORM

If you would like to participate in the Family Medicine Preceptorship or Service Project Program, please complete this form and return it to the Regional Programs Central Office, Central Bldg., Room M1/148B by January 31, 2017.

Note: Do not submit this form without confirmation of preceptor, dates, and your signature.

STUDENT INFORMATION

☐ FM Preceptorship (4 weeks) ☐ Community Health/QI/Service Option (additional 4 weeks)

Name (*Must match name on W9 form*): _____

Current Class: ☐ M1 ☐ M2 DOB: _____ SSN: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ UAMS email address: _____

Address to Send Stipend Check (if different from above): _____

PHYSICIAN/PRECEPTOR INFORMATION

Complete this section on the Physician/Preceptor you have selected from the approved list or a physician approved in advance by the Regional Programs Central Office:

Physician's Name: _____ Email address: _____

Name of Clinic: _____ Region: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Telephone Number: _____ Office Manager: _____

Dates of Preceptorship: Starting _____ Ending _____

I have talked with my Physician/Preceptor and confirmed the arrangements & dates.

*Student signature*_____ Date: _____

Community Health Project (if participating): Please give a brief description of your proposed service project:

_____

Date Received in Regional Programs: _____ By: _____