



General
Internal
Medicine
Statewide
Preceptorship
Program



Preceptor Application

Please Print

Name: _____ MD FACP DO Male Female
First Middle Last Designation Gender

Name of Clinic / Practice: _____

Address: _____
City State Zip

Phone: _____ Fax: _____ County: _____

E-mail: _____ Office Contact: _____

Referred By: Colleague _____ Student _____
 Newsletter _____ Other _____

Physician Profile

Date of Birth: _____ License Number: _____

Medical School Attended: _____

Residency Program: _____

Additional Training/Fellowships: _____

Board Certification in IM (Year): _____ Recertification (Year) _____

What year did you begin practicing in this community? _____

Briefly describe your involvement in community medicine (i.e. County health office, migrant workers clinic, hospital utilization committees, etc.): _____

Other professional involvement (board membership, committee work, etc.): _____

Are you a member of the American College of Physicians (ACP)? Yes No

Practice Characteristics

Type of Practice: Solo Single Specialty Group Multiple Specialty Group
 HMO Hospitalist Other: _____

Number of Physicians in office: _____

Specialties Represented in Clinic: _____

Which of the following are employed in your office:

RN LVN PA NP Nurses' Aid Lab Tech X-ray Tech

Social Worker Other: _____

Practice Characteristics (continued)

Approximately what percentage of your practice is:

_____ % General Internal Medicine/**Primary Care**

_____ % Subspecialty IM, please indicate: _____

Approximately what percentage of your practice is:

_____ % Office - number of patients you see per day: _____

_____ % Hospital - number of patients you see per day: _____

Hospitals at which you make rounds: _____

Approximately what percentages of your patients are:

_____ % Male _____ % White _____ % 11-25 years old

_____ % Female _____ % African American _____ % 26 - 55 years old

_____ % Hispanic _____ % over 55 years old

_____ % Asian

_____ % Other: _____

What languages do your patients speak? English Spanish Other: _____

Is your practice located in a Medically Underserved or Rural area? Yes No

Please list your most common procedures and the approximate number performed each month:

Information for Students

Can you help secure free or low cost housing for a student during the rotation?

Yes No Maybe

Type of housing: Spare room in my home Other: _____

Do you take weekend calls? Yes No

Are students expected to take weekend calls? Yes No

On average, students will be expected to work _____ hours/week.

Students are allowed to perform assist observe with history taking, physical exams and vital signs.

Do you have Internet access available in your office for the student? Yes No

Licensure and Signature

Are you licensed to practice medicine in the state of Texas? Yes No

Have you ever lost clinical/hospital privileges due to any disciplinary actions? Yes No

Please explain: _____

Have your disciplinary actions been cleared? Yes No

Signature: _____ Date: _____

Please return completed form to:

GIMSPP - 401 W. 15th Street, Suite 700, Austin, TX 78701-1680

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