



**University of Georgia College of Pharmacy  
Preceptor Application**

Date \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Maiden Name if Applicable: \_\_\_\_\_

Job Title: \_\_\_\_\_ Gender:  M  F

Office Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Pager: \_\_\_\_\_ PIN: \_\_\_\_\_ Cell: \_\_\_\_\_

Preferred Email Address: \_\_\_\_\_

Alternate Email Address: \_\_\_\_\_

Site Name: \_\_\_\_\_

Site Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Type of practice (e.g. Community, Primary Care, Inpatient, etc): \_\_\_\_\_

Specialty (Community, Oncology, Critical Care, etc): \_\_\_\_\_

**Education/Degrees**

Institution Attended	Dates Attended	Degree

**Post Graduate Training (Residency, Fellowship, etc)**

Post-Graduate Program	Dates Attended	Completion Date

**Employment History**

Position	Employer	Dates

**Professional Licensure**

State Where Licensed to Practice	License Number



### Site Information

Does your site have internet access?  Yes  No

Are you a preceptor for other schools or colleges of Pharmacy?  Yes  No

If yes, which schools or colleges? \_\_\_\_\_

Time the student is expected to be at the site (e.g. Mon-Fri- 7:00-5:00): \_\_\_\_\_

Do you provide a work/study area for the student?  Yes  No

Do you provide an area for the students to store belongings?  Yes  No

Average amount of time you have to spend with the student on a daily basis. \_\_\_\_\_

Please provide descriptive information about your practice site so students can make informed choices about rotation assignments. Briefly describe the type of experience a student would have at your site and indicate any special features that make your rotation experience unique.

List 3 major learning objectives that your rotation can provide students.



**Skip to the next section if your site already has our students on rotations**

Personnel with whom student will rotate on your rotation. Check all that apply	<input type="checkbox"/> BS Pharmacist <input type="checkbox"/> Pharm D <input type="checkbox"/> Pharm Resident/Fellows <input type="checkbox"/> MS <input type="checkbox"/> PhD	<input type="checkbox"/> Pharm Techs <input type="checkbox"/> Clerks <input type="checkbox"/> MD <input type="checkbox"/> PA or NP <input type="checkbox"/> Others -specify
Clinical/Professional Services Check the area(s) that you provide service in:	<input type="checkbox"/> Ambulatory care clinic <input type="checkbox"/> Community Hospital <input type="checkbox"/> Teaching Hospital <input type="checkbox"/> Tertiary Hospital <input type="checkbox"/> Chain Pharmacy <input type="checkbox"/> Independent Pharmacy <input type="checkbox"/> Long term care facility <input type="checkbox"/> Clinical research <input type="checkbox"/> Drug information center <input type="checkbox"/> Drug utilization reviews <input type="checkbox"/> Health screening clinic <input type="checkbox"/> Patient discharge consult <input type="checkbox"/> Pharmacist involved on code teams <input type="checkbox"/> Pharmacist involved on daily rounds <input type="checkbox"/> Pediatrics- inpatient <input type="checkbox"/> Pediatrics- outpatient <input type="checkbox"/> Medicine service <input type="checkbox"/> Primary Care	<input type="checkbox"/> Pharmaceutical Industry <input type="checkbox"/> Critical Care Unit <input type="checkbox"/> Health Department <input type="checkbox"/> Physician's office <input type="checkbox"/> Government <input type="checkbox"/> Mental Health Facility <input type="checkbox"/> Pharmacokinetic monitoring <input type="checkbox"/> P&T Committee functioning <input type="checkbox"/> Pharmacy newsletter <input type="checkbox"/> Poison Control Center <input type="checkbox"/> OTC counseling <input type="checkbox"/> Disease state management <input type="checkbox"/> Immunizations <input type="checkbox"/> Nutrition support <input type="checkbox"/> Oncology <input type="checkbox"/> Cardiology <input type="checkbox"/> Consultant Rx <input type="checkbox"/> Nuclear <input type="checkbox"/> Other services:
IV Admixture Programs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable to this site Computer supported <input type="checkbox"/> Yes <input type="checkbox"/> No TPN Compounding <input type="checkbox"/> Yes <input type="checkbox"/> No Approximate # Units/Day <input type="checkbox"/> <50 <input type="checkbox"/> 50-100 <input type="checkbox"/> 100-200 <input type="checkbox"/> 200-300 <input type="checkbox"/> >300	
Approximate # of orders/prescriptions filled per/day If applicable	<input type="checkbox"/> <50 <input type="checkbox"/> 301-500 <input type="checkbox"/> 50-100 <input type="checkbox"/> >500 <input type="checkbox"/> 101-300 <input type="checkbox"/> N/A	
Number of RPh's per shift responsible for the above orders/prescriptions:		
Number of techs per shift responsible for the above orders/prescriptions:		
Distribution Systems Check all that apply	<input type="checkbox"/> Computer supported <input type="checkbox"/> Unit Dose <input type="checkbox"/> Floor stock <input type="checkbox"/> Robotics <input type="checkbox"/> Bulk packaged, multiple days supply sent to nursing unit for each patient	

Upon completion of this form you can email it directly to: [lhwelch@uga.edu](mailto:lhwelch@uga.edu) or fax it to (706) 542-6022 to the attention of Lindsey Welch, Pharm.D., APPE Director.