Idaho State University
Physician Assistant Studies

PRECEPTOR RESPONSE FORM
CLINICAL YEAR 2025-2026
PLEASE RETURN THIS FORM TO

Phone: 208-282-2923

Email: maryobyrne@isu.edu

Preceptor Name			☐ MD ☐ DO ☐ PA-C ☐ APRN
Preceptor Email			
Preceptor Phone Number		Preceptor Birth Date	
Preceptor Fax Number (optional)			

Preceptor is available to precept students IN THE 2025-2026 CLINICAL YEAR (8/25/25 - 7/31/26)? ☐ Yes ☐ No

If yes, please indicate the total number of students you will precept during the clinical year? _____

CV is attached (please only select "no" if you have previously precepted for ISU)? ☐ Yes ☐ No

Preceptor is available to precept during the following rotation timeframes (please check at least one or all that apply):

Rotation Number & Date	Y/N	Rotation Number & Date	Y/N
#1 – 08/25/2025- 9/26/2025	☐ Yes ☐ No	#5 – 02/16/2026– 03/20/2026	☐ Yes ☐ No
#2 – 10/06/2025- 11/7/2025	☐ Yes ☐ No	#6 – 03/30/2026– 05/01/2026	☐ Yes ☐ No
#3 – 11/17/2025– 12/19/2025	☐ Yes ☐ No	#7 – 05/18/2026–06/19/2026	☐ Yes ☐ No
#4 – 01/05/2026– 02/06/2026	☐ Yes ☐ No	#8 – 06/29/2026– 07/31/2026	☐ Yes ☐ No

Preceptor is available to precept students in the following areas (please check at least one or all that apply):

If you are working a schedule less than 32 hours per week, please add details in the notes section.

☐ Emergency Medicine	☐ General Surgery	☐ Internal Medicine	☐ OB/GYN (Women's Health)
☐ Outpatient (Family Medicine)	☐ Pediatrics	☐ Psychiatry	☐ Other:

Preceptor Primary Location (main facility where preceptor sees patients):

PRIMARY PLACE OF BUSINESS					
Address	**City**	**State**	**Zip**	**Phone**	**Name, title and email of Primary Contact (example: office manager)**

Will this preceptor see patients at any other facility? ☐ Yes ☐ No

If YES, Page two of this document must be completed, as the student will have to be credentialed at all facilities.

IN ORDER TO SAVE YOUR RESPONSES TO THE FORM, PLEASE DOWNLOAD, COMPLETE, RETITLE, AND SAVE TO YOUR COMPUTER, THEN EMAIL THE NEWLY SAVED FILE TO maryobyrne@isu.edu.

FOR ISU USE ONLY: Verified by:_____ Date: _____ Spoke with: _____

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Additional facilities where preceptor sees patients (i.e., clinics, hospitals, nursing homes, etc)

Additional Facility Name:				
Address	City	State	Zip	Phone
Additional Facility Name:				
Address	City	State	Zip	Phone
Additional Facility Name:				
Address	City	State	Zip	Phone
Additional Facility Name:				
Address	City	State	Zip	Phone
Additional Facility Name:				
Address	City	State	Zip	Phone
Additional Facility Name:				
Address	City	State	Zip	Phone

Additional Notes:

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(Form PR01032019)