Rural Physician Associate Program (RPAP)
New Site Application Form
(Please type or print legibly. Use additional sheets as necessary)

Clinic Information *(Please include clinic brochure if available)*

Clinic Name	**Phone** ( )	**Fax** ( )
Address	**Total # of MD's** _____ Family Practice who do OB _____ Family Practice who not do OB _____ OB/GYN _____ Pediatrics _____ General Surgery _____ Emergency Medicine _____ General Internal Medicine _____ Surgical Specialties (specify): _____ Psychiatry _____ Other Medicine Specialty (specify):	
City, State, Zip		
Manager/Administrator Name (□Mr. □Ms. □Mrs.) **Manager/Administrator Email**		
Office space available for student □ Private □ Shared		

Primary Preceptor Information

Name: Last, First, Middle Initial	**Specialty:** □ Family Medicine □ Other (specify): _____ Board Certified? □ Yes □ No **RPAP Alumni?** □ Yes □ No If yes, Year and Site: _____
Degrees (√ all that apply) □ MD □ DO □ MS □ MPH □ Other (specify): _____	
Percent of work time spent on: ___ Clinical Work ___ Administrative Work ___ Other	
Interests/Hobbies	

Minnesota Medical License #: _____
Malpractice Insurance Carrier: _____
Malpractice Insurance Policy #: _____
Year Board Certified: _____
Year Re-Certified: _____

Additional Primary Preceptor Information *(if shared or taking 2 students)*

Name: Last, First, Middle Initial	**Specialty:** □ Family Medicine □ Other (specify): _____ Board Certified? □ Yes □ No **RPAP Alumni?** □ Yes □ No If yes, Year and Site: _____
Degrees (√ all that apply) □ MD □ DO □ MS □ MPH □ Other (specify): _____	
Percent of work time spent on: ___ Clinical Work ___ Administrative Work ___ Other	

Interests/Hobbies

Minnesota Medical License #: _____
Malpractice Insurance Carrier: _____
Malpractice Insurance Policy #: _____
Year Board Certified: _____
Year Re-Certified: _____

Hospital Information *(Please include hospital brochure and a list of attending/consulting physicians if available)*

Hospital Name	**Phone** ( )	**Fax** ( )
Address	**Number of**	
City, State, Zip	_____ Beds _____ ICU Beds _____ Admissions/year _____ Surgeries/year _____ Deliveries/year _____ Attending Staff _____ Consulting Staff	
Manager/Administrator Name (□Mr. □Ms. □Mrs.)		
Manager/Administrator Email		

Specialists who will work with RPAP students	
General Surgeon	Clinic
Email	City/State
Pediatrician	Clinic
Email	City/State
General Internist	Clinic
Email	City/State
Obstetrician/Gynecologist	Clinic
Email	City/State
Surgical Sub Specialist	Clinic
Email	City/State
Surgical Sub Specialist	Clinic
Email	City/State

Nursing Home /Extended Care Facility Information

Name	**Phone** ( )	**Fax** ( )
Address		
City, State, Zip	_____ **# of Beds**	
Manager/Administrator Name (□Mr. □Ms. □Mrs.)	**Director of Nursing** (□Mr. □Ms. □Mrs.)	

Please enclose copies of the following items to complete the application::

□ Statement of support from hospital administrator and health system/clinic administrator, if different
□ Statement of support from primary preceptor(s)
□ Statement of support from general surgeon
□ Brochure from clinic if available

_____

Name and Title of Signing Party

_____ _____

Signature Date

Please return to: **Rural Physician Associate Program**
MMC 81, 420 Delaware St. SE
Minneapolis, MN 55455
Fax #: 612-624-2613
Email: rpapumn@umn.edu