



# *Physicianship Program Student Continuity Experience*

## PRECEPTOR ENROLLMENT FORM

I wish to volunteer as a preceptor for the *Physicianship Program Student Continuity Experience* at Rush Medical College. I understand that this is a two-year mentoring program, and agree to participate for the full term of the program.

NAME: \_\_\_\_\_

PRACTICE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PAGER #: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

LANGUAGES SPOKEN IN YOUR PRACTICE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

PRACTICE SPECIALTY:     General Internal Medicine     General Pediatrics     Family Practice

Please identify your office hours and preference (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>) by checking the appropriate day. This will better enable us to accommodate your day of preference.

MONDAY 1:00 - 5:00 PM    \_\_\_\_\_

TUESDAY 1:00 - 5:00 PM    \_\_\_\_\_

WEDNESDAY 1:00 - 5:00 PM    \_\_\_\_\_

THURSDAY 1:00 - 5:00 PM    \_\_\_\_\_

ARE YOU WILLING TO PRECEPT MORE THAN ONE STUDENT:     YES     NO

### FOR MORE INFORMATION

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