Rural Physician Associate Program (RPAP)
New Site Application Form

To be completed by new sites or sites who have not had a student in over 5 years.

Clinic Information

Clinic Name: _____ Address, City, State, Zip: _____ _____ Phone: _____ Fax: _____ Clinic Manager/Administrator Name and Email: Credentialing Specialist and/or Educational Training Specialist Name and Email: Office space available for student: Private Shared	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):

Primary Preceptor Information

Name and Email: _____ _____ List all degrees (e.g. MD, DO, MPH): _____ Specialty: _____ Board Certified? ___Y ___N Last Year Re-Certified: _____ Minnesota Medical License #: _____ Malpractice Insurance Carrier: _____ Malpractice Insurance Policy #: _____	Percent of work time spent on: ____ Clinical Work ____ Administrative Work ____ Other RPAP Alumni? ___Y ___N If yes, list site and year: _____ Interests/Hobbies:

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

Name and Email: _____ _____ List all degrees (e.g. MD, DO, MPH): _____ Specialty:	Percent of work time spent on: ____ Clinical Work ____ Administrative Work ____ Other RPAP Alumni? ___Y ___N If yes, list site and year:

Board Certified? ___Y ___N Last Year Re-Certified: ____ Minnesota Medical License #:_____ Malpractice Insurance Carrier:_____ Malpractice Insurance Policy #:_____	Interests/Hobbies:

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

Hospital Name: _____ Address, City, State, Zip: _____ _____ Phone: _____ Fax: _____ Hospital Manager/Administrator Name and Email: Credentialing Specialist and/or Educational Training Specialist Name and Email:	Number of _____ Beds _____ ICU Beds _____ Admissions/year _____ Surgeries/year _____ Deliveries/year _____ Attending Staff _____ Consulting Staff

Specialists interested in working with RPAP students

General Surgeon Name: _____ Email: _____ General Internist Name: _____ Email: _____ Surgical Sub-Specialist Name: _____ Email: _____	Pediatrician Name: _____ Email: _____ Obstetrician/Gynecologist Name: _____ Email: _____ Other Name: _____ Email: _____

Nursing Home / Extended Care Facility Information

Hospital Name: _____ Address, City, State, Zip: _____	Number of _____ Beds _____ ICU Beds _____ Admissions/year

_____ Phone: _____ Fax: _____ Hospital Manager/Administrator Name and Email: Credentialing Specialist and/or Educational Training Specialist Name and Email:	_____ Surgeries/year _____ Deliveries/year _____ Attending Staff _____ Consulting Staff

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

___ Statement of support from health system/clinic administrator
___ Statement of support from hospital 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

_____Date_____
Signature

Please return to:
Rural Physician Associate Program
MMC 293, 420 Delaware St. SE
Minneapolis, MN 55455
Email: rpapumn@umn.edu
*If possible, we prefer these documents to be scanned/emailed to us. Please let us know if you are mailing any documents so that we can watch for them.

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