Preceptor Request

Name: _____

Are you employed by TidalHealth? ____ Yes _____ No

University: _____

Program Enrolled: _____MD/DO _____ PA _____ NP _____ SRNA
_____Other: _____

Address Local to our Area: ____ I am not a local of the Eastern Shore of MD / DE

Street: _____

City, State, Zip: _____

Email: _____

Rotation Information

Rotation Dates or Semester Dates being Requested: _____

If not requesting a continuous rotation, please provide:

- Total number of hours needed: _____
- How many days/hours per week, i.e. One 8 hour day per week: _____

Specialty Type, i.e. family medicine, emergency medicine: _____

Preceptor Type: (check all acceptable / desired choices)

_____ Physician _____ Physician Assistant _____ Nurse Practitioner
_____ Nurse Anesthetist _____ Other: _____

Please return completed form via email to preceptorship@tidalhealth.org

Office Use / Date Received _____