



APP Student Preceptorship Application

Date of Application _____

Student Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____

Phone # _____ Email _____

School Attending: **Approved Affiliated Programs**

- | | |
|---|---|
| <input type="checkbox"/> University of Wisconsin- Madison | <input type="checkbox"/> Winona State University |
| <input type="checkbox"/> Des Moines University | <input type="checkbox"/> University of Wisconsin-Eau Claire |
| <input type="checkbox"/> Concordia University | |
| <input type="checkbox"/> Metropolitan State University | <input type="checkbox"/> Augsburg University |
| <input type="checkbox"/> St Catherine University | <input type="checkbox"/> Viterbo University |
| <input type="checkbox"/> Bethel University | <input type="checkbox"/> University of Minnesota |

School Faculty Contact: _____

Under Graduate Degree: _____

Type of preceptorship requested
(i.e. family medicine, pediatrics, women's health)

Requested timeframe and hours for Preceptorship:
(Maximum 2 semesters)

Include in separate document:

Career goals/Community Involvement

References

CV

Referral Source _____

Administrative use only:
Approved: _____ Date: _____