|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PHYSICIAN ASSOCIATE | | | | | | | | |
| Name |  | | | | **Surname** | |  | |
| Email |  | | | | | | | |
| Telephone |  | | | | **Mobile** | |  | |
| Date Registered on the National Register | | | | |  | | | |
| Date Employed by the Practice | | | | |  | | | |
| PRACTICE | | | | | | | | |
| Name of Practice | | | | |  | | | |
| Address of Practice | |  | | | | | | |
| Name of Practice Manager | | |  | | | | | |
| PRECEPTORSHIP | | | | | | | | |
| Will the preceptorship programme be undertaken for a minimum of 1 year (WTE) | | | |  | | | | |
| Is the preceptorship programme wholly in primary care? | | | |  | | | | |
| If not, a minimum of 50% or 6 months’ full time equivalent in any rotation of placements should be in primary care. Is this the case? | | | |  | | | | |
| How many dedicated sessions per week is for education? | | | |  | | | | |
| Does the physician associate have access to an educationally approved primary care clinical supervisor? | | | |  | | | | |
| Name and contact details of the clinical supervisor | | | |  | | | | |
| Does the physician associate have a mentor? | | | |  | | | | |
| Name and contact details of the mentor | | | |  | | | | |
| Please confirm that the physician associate will have an induction period and indicate the start date and end date of the induction period | | | |  | | | | |
| Please confirm that the physician associate will have an induction meeting with their supervisor | | | |  | | | | |
| Please confirm that the physician associate will have a mid-point review meeting. | | | |  | | | | |
| Please confirm that the physician associate will have an end of programme review meeting | | | |  | | | | |
| Please confirm that you will use suitable supportive records of the preceptor’s progress (e.g. [FPARCP First Year Qualification Guidance](https://www.fparcp.co.uk/employers/guidance)) | | | |  | | | | |
| Please confirm that the preceptor will take part in the annual appraisal system | | | |  | | | | |
| Please confirm that the physician associate will have access to professional development programme from a local HEI or equivalent, which should include alumni activity | | | |  | | | | |
| Please list the training courses the physician associate will attend during the preceptorship programme – you will be expected to send the details (dates, cost, certificates, trainer etc.) of all training sessions to Camden CEPN once the preceptorship ends | | | |  | | | | |
| Please confirm that the physician associate will attend at least 3 training courses organised by Camden CEPN | | | |  | | | | |
| Please confirm that the physician associate will attend all PA Network Meetings organised by Camden CEPN | | | |  | | | | |
| Please confirm that the physician associate will complete and maintain all the requirements of the UK PA Managed Voluntary Register (PAMVR) | | | |  | | | | |
| BUDGET BREAKDOWN | | | | | | | | |
| Please provide below a basic breakdown of how you are planning to spend the available £5,000 budget per PA – evidence of actual expenditure should be submitted to Camden CEPN at the end of the preceptorship programme   |  |  | | --- | --- | | ITEM | COST | | Supervision | £ | | Training | £ | | Mentoring | £ | | (Other – pls specify) | £ | | (Other – pls specify) | £ | | TOTAL | **£** | | | | | | | | | |
| SIGNATURES | | | | | | | | |
| Physician Associate |  | | | | | Date | |  |
| Practice Manager |  | | | | | Date | |  |
| Supervisor |  | | | | | Date | |  |
| Camden CEPN Chair |  | | | | | Date | |  |
| Camden CEPN Programme Manager |  | | | | | Date | |  |