



American Association of Physicians of Indian Origin

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**Please mail/email/fax the application to AAPI office*

DATE: _____

AAPI CLINICAL OBSERVERSHIP PROGRAM

PHYSICIAN PRECEPTOR APPLICATION FORM

Full Name: _____

Current Position/Title: _____

Home Mailing Address

City

State

ZIP

Business Mailing Address

City

State

ZIP

Business Phone: _____ Mobile/Pager: _____

E-mail: _____

Medical School: _____ Year of Graduation: _____

Graduate Medical Education: _____

Medical specialty: _____

ABMS certification: _____

American Osteopathic Association certification: _____

Not certified: _____

Unrestricted Medical License: Yes ____ No ____ State/Jurisdiction: _____

License number: _____ Expiration date: _____

Why would you be a good physician preceptor?

What dates and times are you available to be a preceptor?
