ENROLLMENT FORM FOR PRECEPTORS, MENTORS & TUTORS OF GWU MEDICAL STUDENTS SCHOOL OF MEDICINE & HEALTH SCIENCES

Full Name_____ **Department**_____

Citizen of/VISA Status_____ **Affiliation**_____

SSN: _____ - _____ - _____ **Date of Birth:** _____/ _____/ _____

Home Address _____
Home City/State/Zip _____
Home Phone _____

Office Address _____
Office City/State/Zip _____
Office Phone _____

E Mail Address _____

EDUCATIONAL BACKGROUND

Degree(s) Held	Date Awarded	School / Institution

ACADEMIC POSITIONS HELD

Dates	Rank	School / Institution	Status (Full or Part-Time)

Please answer the following:

I am_____ am not _____ Board certified in my specialty (Please indicate specialty _____).

Current Medical Licensure:

State:_____ License #:_____
State:_____ License #:_____
State:_____ License #:_____

I certify that the information contained on this form is complete and accurate to the best of my knowledge.

_____ _____
Signature Date

For Departmental Use Only:

This is to certify that the individual submitting this form is currently an active preceptor, mentor or tutor for the GWU School of Medicine & Health Sciences.

_____ _____

Program Director Date

Please return this form to your department's Faculty Affairs Administrator for submission. Do not send directly to the GWU Office of Faculty Affairs