

**APPLICATION FOR PRECEPTORS, MENTORS & TUTORS OF  
George Washington University School of Medicine  
MEDICAL STUDENTS**

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Date Completed \_\_\_\_\_

Full Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Home City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_

Office Address \_\_\_\_\_  
Office City/State/Zip \_\_\_\_\_  
Office Phone \_\_\_\_\_

E Mail \_\_\_\_\_

**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 Board certified in my specialty.
	I am not Board certified in my specialty.

Current Medical Licensure:

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.

\_\_\_\_\_  
Director

\_\_\_\_\_  
Date