



**ACADEMIC PARTNERSHIPS (Student/Observer)  
PRECEPTOR ACKNOWLEDGEMENT FORM**

*Note: Form should be submitted 30 days prior to the rotation start date.*

Date: \_\_\_\_\_ Student/ Observer Name: \_\_\_\_\_

School Name: Medical College of Georgia

Program Name: Observership If Medical Student, what year? 1 2 3 4

Dates of Rotation: Start: \_\_\_\_\_ End: \_\_\_\_\_

**\*\*Observers may not participate in patient care and only allowed a maximum two consecutive calendar weeks and/or 80 hours \*\***

*I understand that WellStar Health System assumes no responsibility for the care of this student/observer if injured while under my preceptorship.*

*I understand and agree to comply with WellStar's scope of practice outlined for students/observers in this program. I understand the student/observer has no independent access to any non-public area while at Wellstar. When in patient care or other clinical areas I understand and agree it is required that I or my designee will be with the student/observer at all times. Failure to comply with this provision may result in immediate termination of the current rotation.*

*I understand and agree to accept full responsibility for the proper conduct of this student/observer listed above in this form, for observance of all Bylaws, Rules & Regulations and Policies of the Hospital(s) and Medical Staff(s), and for the correction and resolution of any problems that may arise during student's training rotation with me.*

Preceptor Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Preceptor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License number: \_\_\_\_\_ Specialty: \_\_\_\_\_

Medical Practice/ Department : \_\_\_\_\_

Wellstar Hospital Affiliation: Wellstar MCG Health