



# Practice Site Data Collection Form Elective

**DIRECTIONS:** Please complete all the information on this form and return to the Director of Experiential Education at the School of Pharmacy by email, fax or mail. Email this form by saving and sending it as an attachment OR for those with Outlook, click on the "Submit by Email" button at the top of your page. Please make the subject line: "Practice Site Data Collection Form".

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## SITE CONTACT INFORMATION

Site Name: \_\_\_\_\_

Site Address: \_\_\_\_\_

City State Zip

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

Practice Site Preceptor Name: \_\_\_\_\_ Practice Site Preceptor Title: \_\_\_\_\_

## PRACTICE SITE INFORMATION

Type of Practice (Choose One):

If Other, please describe here: \_\_\_\_\_

Select Appropriate Location (Choose One):

Patient Types (Select all that apply):  Acute  Ambulatory  Extended Care  Other \_\_\_\_\_

**Description of Rotation/Practice Site** (Please briefly describe your rotation/practice site. This description will be used to help students select their rotations.)

**Briefly state practice site mission**

**PRACTICE SITE INFORMATION (Continued)**

HIPPA compliant

Pharmacist(s) practice as part of a inter-professional team.

**If Yes, describe:**

Site Recognition (Select all that apply):

ADA     JCAHO    List Other: \_\_\_\_\_

Organization or administration supportive of education mission

**Comments:**

Organization or administration encourages CQI programs & staff development

**Describe:**