Department of Radiologic Sciences
The Shimadzu School of Radiologic Sciences
Robert D. & Carol Gunn College of Health Sciences and Human Services
3410 Taft Boulevard Wichita Falls, Texas 76308-2099
Office: (940) 397-4337 or (940) 397-4575
Toll Free: 1-866-575-4305 FAX (940) 397-4845
Internet: http://www.msutexas.edu/academics/hs2/radsci

RADIOLOGIST PRECEPTOR WRITTEN AGREEMENT

I agree to serve as the Radiologist Preceptor without remuneration for _____ as he/she completes the MSU Radiologist Assistant Master's Degree.

I have reviewed the online MSU RA Program information and understand that the clinical component of the program runs five (5) semesters (Summer-Fall-Spring-Summer-Fall). Students must take the RA courses in the order indicated on the RA curriculum. Students are required to attend seminar classes on the MSU campus twice each semester and must have reliable access to computers to complete online course requirements throughout each semester. Students must meet all program requirements including demonstrated competence in the specified number of General Diagnostic Clinical Competencies and the specified number of Elective Clinical Competencies to successfully complete the program. Upon completion of the program students will receive a Master of Science in Radiological Science degree for the MSU RA Program.

I understand and accept that my responsibilities as Radiologist Preceptor include, but are not limited to:

- Teaching and guiding the RA student as he/she develops overall RA clinical skills.
- Supervising and overseeing RA student interactions with patients.
- Teaching, evaluating, and documenting successful completion of the RA Clinical Competencies (Required and Elective) as identified by the MSU RA curriculum.
- Verifying that the RA student has at least twenty four (24) clinical contact hours per week to develop RA clinical skills each semester.
- Maintaining communication with the MSU faculty about the progress of the RA student in the RA program.

I understand that the student MUST have a Radiologist Preceptor to participate in the MSU Radiologist Assistant Program. I understand the student will function under the affiliation and privileges extended to the radiologist or radiology group by the facilities served.

If, for any reason, I cannot continue to serve as this student's preceptor, I will immediately notify the MSU RA program. I understand that the student must identify another radiologist willing to serve as Radiologist Preceptor to remain in the MSU RA Program.

Signed, _____

Radiologist Preceptor Name / Date

_____

Printed Radiologist Name

_____

Authorizing Signature for Group Practice / Date

Revised 04/25

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Student Name: _____

Clinical Site Information

Facility name:

Address:

Preceptor Information

Name:

Address:

Phone #:

Email:

Please indicate below how they would prefer to be contacted:

Email **and/or** mail address: