



PALMER

College of Chiropractic

WEST CAMPUS

**POSTGRADUATE PRECEPTORSHIP
PROGRAM**

**PROGRAM GUIDELINES AND
APPLICATION**

The Trusted Leader in Chiropractic Education[®]

POSTGRADUATE PRECEPTOR PROGRAM PC521

PROGRAM GUIDELINES

I. Palmer's West Campus Preceptorship Program

Palmer College of Chiropractic's West Campus has chosen to enhance its continuing education curriculum by providing graduates with the opportunity to gain pre-licensure experience by working with practicing doctors of chiropractic.

A. Purpose

This program provides practical clinical and business experience to graduates via a program that is overseen by Palmer College of Chiropractic's West Campus. Additionally it provides the preceptor assistance and encourages continuing graduate education of licensed field doctors and unlicensed graduates through a close relationship with an academic institution.

B. Objectives of the Preceptorship Program

Preceptorship Program goals are: To gain practical clinical and business experience and to become acquainted with members of the chiropractic profession in the preceptorship state of residence. To provide an avenue for the Intern to learn office reporting procedures peculiar to the location of preceptorship, to provide access to possible associate positions, and to act as a spring board to successful chiropractic practice.

C. California State Code of Regulations, Section 312

Under Section 312 of the laws and regulations relating to the practice of chiropractic in the state of California; "An "unlicensed individual" is defined as any person, including a student or graduate of a chiropractic institution, who does not hold a valid California chiropractic license. An exemption is hereby created for student doctors participating in board approved preceptorship programs." Further in that section it states; "Students doctors participating in board approved preceptorship programs are not to be considered "unlicensed individuals" when working in said program."

The executive director of the Board of Chiropractic Examiners also states that; "The Board considers individuals holding chiropractic college degrees (graduates) who are enrolled in course work and board-approved preceptorship programs as also meeting the exemption requirements of that section."

II. DEFINITIONS

Preceptorship Program - A program approved and administered by Palmer's West Campus.

Preceptor - A doctor of chiropractic who is approved and appointed by the West Campus to act as a supervisor the Preceptorship Program.

Intern/Preceptee - A graduate from a chiropractic college approved by the CCE, and is enrolled in the Palmer College of Chiropractic's West Campus Preceptorship Program.

Direct Supervision – The Preceptor (licensed DC) must be physically present and available on the clinic premises during all times that the Intern (unlicensed, graduate DC) is involved in patient care activities.

Clinic Standards Committee - The West Campus oversight committee tasked with providing program guidance, and Intern/preceptor participation approval. This committee also reviews

applications for Preceptors, approves Preceptor appointment or re-appointment, and adjudicates when Intern or Preceptor actions warrant it.

III. Preceptor: Requirements, Responsibilities, Term and Fees.

A. Requirements

To appoint a field doctor chiropractor as a West Campus Preceptor, to supervise an Intern, he/she must meet the following requirements:

1. Submit a completed West Campus Preceptor Application Form and all other requested data to the director of the Preceptorship program for review and approval.
2. Hold a current and valid license to practice chiropractic.
3. Have at least four (4) years active experience in the practice of chiropractic as a licensee of the state in which he/she is currently practicing.
4. Have no record of disciplinary action based on any violation of the California Chiropractic Initiative Act or regulations of the state he/she is currently practicing in; or the conviction, or plea of nolo contendere to, any offense whether felony or misdemeanor which is substantially related to the practice of chiropractic.
5. Have a professional liability insurance policy in effect. The company writing that policy is admitted to the office of the State of California Insurance Commissioner or the state in which the field training is being conducted. Coverage shall be in the minimum amount of \$1,000,000 per case/\$3,000,000 aggregate loss.
6. Agree to abide by the rules and regulations of the Program as written in the program guidelines and other correspondence.
7. Office appearance must be professional and available for inspection by a doctor of chiropractic prior to appointment as a West Campus Preceptor.
8. Agree to periodic announced and unannounced visits, and phone calls, by the West Campus Program Director or his/her designee.

B. Responsibilities

Once appointed by the West Campus, the Preceptor will:

1. Be responsible for and provide direct supervision of all chiropractic services rendered by the Intern. The Preceptor will be physically present in the same office or facility when the Intern is treating any patient.
2. Assign only those patient services that can be safely and effectively preformed by the Intern.
3. Ensure that the Intern is clearly identified to patients as an Intern or Preceptee and not a licensed doctor by wearing a name tag identifying him/her as such.
4. Ensure that a signed informed consent form is obtained from each patient before the Intern renders an examination, physical therapy, or chiropractic treatment to the patient.
5. Ensure that the Intern practices in accordance with federal and state statutes and regulations relating to health care practices in the state of the preceptorship.
6. File with the Program Director monthly and final progress reports.
7. NOT supervise a total of more than two (2) Interns, nor can there be more than two (2) Interns in one physical location, regardless of how many doctors practice there.
8. Be responsible for knowing and adhering to the laws of their state with regard to acceptable scope of practice (patient care, marketing rules and regulation, radiography, etc) and reporting requirements for Postgraduate Preceptorships.

9. Notify the Program Director as soon as possible in the event he/she decides to discontinue participation in the Program
10. Be familiar with the Rights and Privacy Act of 1974 as Amended

C. Term of appointment

1. Will be for 4 consecutive quarters or a maximum of one year for any one Intern.
2. The term is automatically renewed for that Preceptor doctor, without additional fees, as long as the status remains active and current.
3. Failure to participate in the program for a period of three (3) years may require the Preceptor to reapply for the program.
4. Participation in this program is entirely voluntary by both Preceptor and Intern. Palmer College of Chiropractic's West Campus is not responsible for decisions of Preceptors or Intern to discontinue participation in the Program.

D. Fees

1. There is no application or participation fee for Preceptors. Interns participating in the Postgraduate program pay a quarterly registration fee of \$225.
2. All fees are non-refundable and subject to change without notice.

IV. Intern: Requirements, Term and Responsibilities

A. Requirements

1. Participation in this program is entirely voluntary by both Preceptor and Intern. Palmer College of Chiropractic's West Campus is not responsible for decisions of Preceptors or Preceptees to discontinue participation in the Program.
2. To be eligible for the program, the applicant (unlicensed D.C.) must have graduated from an accredited chiropractic college within the past year. Applicants who were licensed in another state or country are eligible to participate in the program.
3. Applicants must complete and submit all components of the application and required fees as outlined on the Intern Application. Applications are to be mailed to the "Postgraduate Preceptorship Program" at Palmer's West Campus address.
4. Participation in the program is limited to a period of one-year from the date of graduation at which time the program will be discontinued and the Preceptee must cease all patient care activities beyond those which an unlicensed D.C. may perform.
5. Once approved for the program, preceptees must register (course PC521) and pay for the program each academic quarter to continue participation. Failure to complete registration process and/or pay fees will be considered voluntary termination from the program.
6. Applicants for the Preceptorship Program who are **not Palmer (any campus) graduates** are required to have a copy of their **official** transcript sent to the Postgraduate Preceptorship Office, Palmer College of Chiropractic's West Campus, as proof of graduation.
7. A registration/application fee of \$225.00 for the first quarter is required to begin processing the application. An additional fee of \$225.00 is due at the beginning of each subsequent academic quarter of participation. Fees are not prorated, are non-refundable, and are subject to change without notice.

B. Term

1. Approved Preceptees may participate in the program for a period of one-year from the date of their graduation, until licensure, or voluntary termination. Preceptees are required to inform the Postgraduate Preceptorship Program of receipt of their license or voluntary termination from the program.
2. Preceptees may not average more than 35 working hours per week in the Preceptor's office.
3. If controversial Intern actions or behavior is reported and determined to be unsuitable or unprofessional by the West Campus Dean of Clinics, the Intern may be terminated from the Program immediately. A report may be made to the Board of Chiropractic Examiners of any dismissal or termination from the program of an Intern.

C. Intern Responsibilities

While engaged in the West Campus Preceptorship Program the Intern will meet the following responsibilities:

1. The Intern shall not provide chiropractic services without the required direct supervision and approval of the approved Preceptor and shall not provide any services that he/she has not obtained instruction in while a student and/or is not competent to perform.
2. The Intern will not deviate from the Preceptorship program as written herein.
3. The Intern will not represent himself/herself as being a licensed doctor of chiropractic and will wear a name tag clearly identifying him/her as an "Intern" or "Preceptee". Advertising by an Intern is considered unprofessional conduct.
4. The Intern will comply with the applicable federal and state laws and regulations relating to health care practice in which they are performing the preceptorship.
5. Preceptees may NOT participate in the assessment or care (including physiotherapy) of Medicare patients.
6. The Intern will report immediately to the Director of the Preceptorship Program any delay, interruption or termination of the program.
7. The Intern, Preceptor and Patient will sign the Informed Consent form for each patient prior to performing any treatment on that patient. This form obtains written acknowledgement from the patient that they consent to be treated by an unlicensed D.C. participating in an approved Preceptorship Program.
8. In the event the Intern decides to terminate the preceptorship arrangement, the Intern will provide the Preceptor with notice.

V. Remuneration/Financial Arrangements

- A. Remuneration arrangements between Preceptor and Intern is considered a legal financial arrangement and PCCW does not participate in any such arrangement and is held harmless in the event either party fails to comply with those arrangements.
- B. Both Preceptor and Preceptee are encouraged to consult with professional advisors on establishing appropriate financial arrangements
- C. In California, preceptees **MUST** be hired as employees and may not be Independent Contractors (against California Code for an Unlicensed DC to own a chiropractic practice)

VI. Revocation of Preceptor Appointment and Termination of Intern participation in the Preceptorship Program.

A. Revocation.

The Board of Examiners or Program Director may deny, suspend, revoke, or place on probation a Preceptor appointed by Palmer College of Chiropractic's West Campus for any of the following reasons:

1. Failure to comply with the State, College and/or program regulations of the preceptorship program.
2. Violation of the California Chiropractic Initiative Act or state regulations; or the conviction, or plea of nolo contendere to, any offense whether felony or misdemeanor which is substantially related to the practice of chiropractic.
3. False or misleading information presented to the West Campus with respect to the preceptor program.
4. The Intern has violated the Chiropractic Initiative Act or state regulations regardless of whether the Preceptor has knowledge of the acts performed.
5. The failure to obtain a signed informed consent form from any patient prior to allowing the Intern to begin an examination, chiropractic treatment or physical therapy treatment.

B. Termination

Termination of Intern participation in the Preceptorship Program may result in future denial, suspension, revocation or placement on probation of a state license to be issued to an Intern in the Program for any the following reasons:

1. Failure to comply with the State, College and/or program regulations of the preceptorship program.
2. Violation of the California Chiropractic Initiative Act or state regulations; or the conviction, or plea of nolo contendere to, any offense whether felony or misdemeanor which is substantially related to the practice of chiropractic.
3. False or misleading information presented to the West Campus or the Board of Examiners with respect to the Preceptorship Program.
4. The rendering of a chiropractic service outside the preceptorship program.
5. Rendering of chiropractic services under a doctor/preceptor of chiropractic who is not approved as a preceptor or whose registration/appointment as a preceptor has been suspended or revoked.
6. The failure to obtain a signed informed consent form from any patient prior to the Intern beginning an examination, chiropractic treatment or physical therapy treatment.

VII. Additional Items

- A. **Geographic Location.** Preceptorships may take place anywhere within the State of California or other locations at the discretion of the Dean of the College. Preceptorships may not occur in states, or Countries outside the United States, that do not have official government bodies that recognize (license, oversee or otherwise direct) practices of chiropractic.
- B. **Reporting.** Each Preceptor will send to the Program Director a completed and signed Monthly Report on Intern performance. Failure to submit past due reports at the time of registration for the next quarter may potentially result in termination of the program.

C. **Confidentiality.** All program reports, profiles and applications will only be used by the West Campus for any purposes outlined in this document. All parties will make themselves familiar with the Privacy Act of 1974 as Amended and will adhere to it in all circumstances.

D. **Retention of Records.**

1. **Preceptor Records.** Applications of potential Preceptors will be retained while actively acting as a Preceptor or for one-year after the Preceptor becomes voluntarily inactive.
2. **Intern Records.** Reports pertaining to Interns will be retained while active in the Postgraduate Program and then for one-year after completion or termination from the program and then destroyed.

Palmer College of Chiropractic's West Campus
90 East Tasman, San Jose, CA 95134
Phone (408) 944-6036
Fax (408) 944-6093

POSTGRADUATE PRECEPTOR PROGRAM PC521

PRECEPTOR APPLICATION PACKET

POSTGRADUATE PRECEPTOR PROGRAM PC521

Preceptor (Field Doctor)

Application Checklist

The **underlined** items below must be returned as part of the Preceptor's application for the program. The remaining items (not underlined) are to be retained by for information purposes.

- [] Read the abridged preceptorship program guidelines on the Palmer Webpage.
- [] **Preceptor Application** - Please complete and sign.
- [] **Preceptor Statement of Understanding** – Please review, complete and sign.
- [] **Preceptor Acceptance Letter** - After you and your Intern have agreed on all matters, i.e. work hours, days, and remuneration, please complete and sign.
- [] **Rights and Privacy Act as Amended** - Please review and retain for your records.
- [] **Appointment of Certificate Holder** - provides updates on any changes in your policy and allows your carrier to confirm malpractice coverage is in place.
- [] **Patient Acknowledgement form.** This optional form for use in your office provides written acknowledgement by the patient that they consent to be treated by an unlicensed D.C. under the licensed DC's supervision. Please retain for use once the Intern begins rendering patient care.
- [] **Monthly Evaluation Report** - Please photocopy for future use and submit monthly reports.

Please return the **underlined** forms above along with the following:

- [] Current **Doctor of Chiropractic License**
- [] Current **Malpractice Declarations page** (one showing limits and expiration date).
- [] Current **X-Ray Operator and Supervisor's Permit** (or like certification, if applicable).

IMPORTANT NOTICE: **Interns may NOT begin participating in patient care activities under the Post Graduate Preceptorship Program until the office has received written or verbal communication from the program director indicating the program has been approved.** This will occur after proof of malpractice for the intern has been submitted to the office. Receipt of the ***Verification of Completion*** form (by fax), signed by the director with the start date noted, will serve as written verification. In most situations, a phone call will also be made to the office to inform that the program has been approved.

POSTGRADUATE PRECEPTOR PROGRAM PC521

PRECEPTOR (FIELD DOCTOR) APPLICATION

Date _____

Doctor's Name _____

Office Address _____ City _____ State _____ Zip _____

Office Phone # (_____) _____ Fax # (_____) _____

Email Address: _____ Website: _____

DC College graduated from: _____ Date _____

DC license # _____ Exp. date _____ Date initially issued _____

Malpractice Carrier _____ Expiration Date _____

X-ray Certificate # _____ Expiration Date _____

Are you currently facing, or have you ever been subject to action by the state board? [] Yes [] No

Have you ever had your license suspended or revoked in this or any other state? [] Yes [] No

Have you ever been convicted of a crime? [] Yes [] No

Are you applying for a specific student? [] Yes [] No

If "Yes", please enter the student name _____

If "No", reason for applying _____

Check the statement, which most accurately reflects your interest in our program.

- () I am interested in participating in this program on a regular basis.
- () I am only interested in participating in this program for the student named above.
- () I am unsure at this time as to my future participation in this program.

Your Highest Degree of Education completed other than the D.C. is:

- [] High School [] Bachelor's Degree
- [] Two years of college [] Maser Degree
- [] Ph.D./Equivalent

Primary practice model is (please number in order of most frequent (i.e. 1, 2, 3)):

- [] General practice [] Workers compensation [] Personal injury
- [] Sports [] Pediatrics [] Other: _____

Type of technique practices (please number in order of most frequent (i.e. 1, 2, 3)):

- | | | |
|---|---|---|
| <input type="checkbox"/> Diversified | <input type="checkbox"/> Gonstead | <input type="checkbox"/> Activator |
| <input type="checkbox"/> Thompson/Drop | <input type="checkbox"/> Cox/Flexion-Traction | <input type="checkbox"/> Biomechanics/CBP |
| <input type="checkbox"/> Pettibon | <input type="checkbox"/> ART/Soft-Tissue | <input type="checkbox"/> SOT |
| <input type="checkbox"/> Upper Cervical | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

Number of New Patients/Month _____ Number of Patient Visits/Month _____

How would you classify your office **patient flow**? High Volume Moderate Volume Low Volume
How would you classify your office **scope of practice**? Broad Scope Moderate Scope Narrow Scope
How would you classify your office's emphasis on **Chiropractic Philosophy**? Strong Moderate Low

Does your office have equipment for physical rehabilitation? Yes No
If "Yes", would you describe your rehab services as (check all that apply):
 high tech low tech frequently used occasionally used

If "Yes", who provides the rehabilitative services?

- | | |
|---------------------------------|--|
| _____ Applicant (Licensed D.C.) | _____ Associate D.C. M.D., D.O. (Circle one) |
| _____ Chiropractic Assistants | _____ Physical Therapist |
| _____ Rehab Therapist | _____ Others |

Please indicate the ancillary procedures provided in your office (check all that apply):
 Heat/Ice Electric Modalities (US, MNS, Diathermy) Cold Laser Graston Technique®
 Active Release Technique® Myofascial Release Technique Surface EMG
 Others (please list): _____

Does your office have an X-Ray machine? Yes No

How many of the following are on your office staff at this time? Please write a number for any that apply, do not duplicate counts. Also put **P** for Part Time and **F** for Full Time next to the corresponding number.

- | | |
|---|-------------------------------|
| _____ Associate D.C., M.D., D.O. (indicate which) | _____ Chiropractic Assistants |
| _____ Physical Therapist | _____ Massage Therapist |
| _____ Receptionist | _____ Other |

Do you maintain a practice in more than one location? Yes No
Will the intern be participating in their FTP at the second (or more) location(s)? Yes No
If "Yes" to either of the above, please list complete office location(s):

Address City State Zip Phone

Address City State Zip Phone

Please indicate the number of rooms in your clinic: _____ Total number
_____ Adjusting rooms _____ Physical Therapy
_____ Reception/Office _____ Doctors office/consultation
_____ Other _____ Approx. total square footage

By my signature and date below, I declare to the best of my knowledge that the information contained in this application is true and correct:

Signature of Field Doctor

Date

Palmer College of Chiropractic's West Campus
90 East Tasman, San Jose, CA 95134
Phone (408) 944-6036
Fax (408) 944-6093

POSTGRADUATE PRECEPTOR PROGRAM PC521

PRECEPTOR STATEMENT OF UNDERSTANDING

I, Dr. _____ DC, have read the provisions of the West Campus Preceptor Program, and I am familiar with all of its ramifications and agree to abide by the Program's requirements. I agree that while the Intern is participating in my office, I will be covered under my professional liability insurance policy. I understand that the Intern has read and signed a separate statement volunteering for this Program and that he/she has set aside any responsibility and/or liability of Palmer College of Chiropractic's West Campus. Interns participating at my office will perform only those procedures that have been deemed ethical and legal by the California State Board of Chiropractic Examiners or the state in which this program is being conducted. I agree to be on the premises at all times when the Intern performs any chiropractic procedures in my office (if allowed by the state and considered appropriate by myself). I understand this agreement to be binding in its terms as long as I remain a Preceptor.

PRECEPTOR ACCEPTANCE LETTER

I have interviewed and agree to accept Intern _____ into my office. In complying with the Program I understand I am responsible for sending to the Program Director a monthly report on the Preceptee's performance. In the event I fail to do this I will be discontinued as a Preceptor and the Intern will be removed from the Program.

RIGHTS AND PRIVACY ACT OF 1974 AS AMENDED

Colleges and their faculties may not disclose information about students or Interns nor permit inspection of their records without the student's or Interns permission unless such action is covered by certain exceptions. Field doctors participating in the Palmer College of Chiropractic's West Campus Preceptorship Programs are covered by this Act.

Violations would include release of any information to anyone other than college officials, whether it is written or oral, without the Interns written permission.

Field doctors should respect the Intern's privacy as they would the privacy of their patients. The field doctor should be acutely aware that discussing his/her Intern's progress in general conversation is not allowed and should know that violation of the Act could result in the withdrawal in the Department of Education funding for Palmer College of Chiropractic's West Campus.

By my signature and date below, I declare that I have reviewed the information above and understand and accept the placement of the above named Intern as a Preceptee in my office(s):

Signature of Field Doctor

Date

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POSTGRADUATE PRECEPTOR PROGRAM PC521

APPOINTMENT OF CERTIFICATE HOLDER

Insurance Company: _____

Company Address: _____

Policy Number: _____

Insurance Telephone #: _____

Insurance Fax #: _____

Name of Insured: _____

Insured Address: _____

My signature and date of this form authorizes my professional liability insurance carrier to appoint as Certificate Holder the Director of the Preceptorship Program of Palmer College of Chiropractic's West Campus.

Certificate Holder: Gregory J. Snow, DC
Palmer College of Chiropractic's West Campus
90 E. Tasman Dr.
San Jose, CA 95136-1617

Signature of Insured

Date

Palmer College of Chiropractic's West Campus
90 East Tasman, San Jose, CA 95134
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POSTGRADUATE PRECEPTOR PROGRAM PC521

PATIENT ACKNOWLEDGEMENT FORM

*Please have all patients receiving care from
the Intern complete and sign this form*

I, (Patient's Name) _____ a patient at
(Office Name) _____ acknowledge that
(Intern's Name) _____ is an unlicensed,
graduate chiropractic Intern assigned to this office through an
approved Preceptorship program regulated by Palmer College of
Chiropractic's West Campus. I acknowledge the Intern's unlicensed
status and consent to receive care from him/her under the direct
supervision of Dr. _____ (Preceptor's Name).

Patient's Signature

Date

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MONTHLY EVALUATION OF INTERN

Date of Evaluation: _____ For the Month of: _____

Intern Name: _____

Doctor Name: _____

Dates of Preceptorship. From: _____ To: _____ (anticipated last date)

Please respond to each of the following using the scale.

1 - SUPERIOR 2 - ABOVE AVG. 3 - AVERAGE 4 - BELOW AVG. 5 - INADEQUATE

1. _____ The Intern is punctual in meeting commitments.
2. _____ The Intern is thorough and accurate in keeping records on patients in her/his care.
5. _____ The Intern is able to arrive at an accurate diagnostic impression.
6. _____ The Intern plans appropriate treatment and patient follow up.
7. _____ The Intern's ability to administer an adjustment meets practice standards.
8. _____ The Intern accepts constructive criticism willingly.
9. _____ The Intern demonstrates ethical and professional behavior.
10. _____ The Intern is able to identify when more advanced testing is required.
11. _____ The Intern is able to identify when a referral is needed.
12. _____ The Intern is able to adequately interpret x-ray, lab and other significant exam.
13. For this month, the Intern has about how many patient interactions? _____

14. Please describe what you feel are this Intern's strengths and weaknesses at this time.

Doctor's Signature _____ Date _____

Please fax to 408-944-6093 on the first of each month.

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POSTGRADUATE PRECEPTOR PROGRAM PC521

INTERN/PRECEPTEE APPLICATION PACKET

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Fax (408) 944-6093

POSTGRADUATE PRECEPTOR PROGRAM PC521

Intern

Preceptorship Program Application Checklist

The **underlined** items below must be returned as part of the Intern's application for the program. The remaining items (not underlined) are to be retained by the Intern for information purposes.

- [] Read the abridged preceptorship program guidelines on the Palmer Webpage.
- [] **Intern Application** - Complete and sign.
- [] **Rights and Privacy Act as Amended** and **Intern Statement of Understanding** - After you and your field doctor have agreed on all matters, i.e. work hours, days and remuneration, please sign.
- [] **Preceptee Preceptorship Program Affidavit** - Please read and sign.
- [] **Patient Acknowledgement form.** This optional form for use in your office provides written acknowledgement by the patient that they consent to be treated by an unlicensed D.C. under the licensed DC's supervision. Please retain for use once the Intern begins rendering patient care.
- [] **Verification of Completion form.** This form must be completed and signed by both the intern and Preceptor. It will be faxed back to the doctor's office once completed to signify the program has been approved and the intern may begin providing care.
- [] **Fees.** A non-refundable application/registration fee of \$225.00 is required with your application. An additional \$225.00 is due for each subsequent quarter of participation. Failure to remit payment for subsequent quarters will result in automatic termination of program.
- [] **Transcript** – an **official** copy of your chiropractic college transcript [waived for Palmer graduates].
- [] **Diploma** – a copy of your Doctor of Chiropractic diploma [waived for Palmer graduates].

IMPORTANT NOTE: Submission of application or fee does NOT guarantee acceptance into the program. **The intern and doctor are accepted into the program only when they receive WRITTEN approval from Palmer's West Campus.** If the intern participates in activities requiring a chiropractic license **BEFORE** acceptance into the program or receiving their license, the graduate and field doctor are open to disciplinary action from the Chiropractic Board.

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Field.training@palmer.edu

POSTGRADUATE PRECEPTOR PROGRAM PC521

INTERN APPLICATION

Date _____

Intern's Name _____

Address _____

City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____

Email Address _____

Graduate of _____ Date _____

Registering for quarter (circle one): Winter Spring Summer Fall 20__

Doctor's Name _____

Office Address _____

City State Zip

Tele # (_____) _____ Fax # (_____) _____

[] \$225.00 Fee enclosed or submitted to business office (make checks payable to "PCCW";
you may call 408-944-6025 to pay by credit card)

Fees are non-refundable and subject to change without notice.

Intern Signature _____ Date _____

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RIGHTS AND PRIVACY ACT OF 1974 AS AMENDED

Colleges and their faculties may not disclose information about students or Interns nor permit inspection of their records without the student's or Interns permission unless such action is covered by certain exceptions. Preceptors (Licensed D.C.s) participating in the Palmer College of Chiropractic's West Campus Preceptorship Programs are covered by this Act and therefore obliged to adhere to the Act.

Violations of the Act would include release of any information to anyone other than college officials, whether it be written or oral, without the Interns written permission.

Preceptors should respect the Intern's privacy as they would the privacy of their patients. The Preceptor should be acutely aware that discussing his/her Intern's progress in general conversation is not allowed and should know that violation of the Act could result in the withdrawal in the Department of Education funding for Palmer College of Chiropractic's West Campus.

INTERN STATEMENT OF UNDERSTANDING

I, _____, have read the appropriate West Campus Preceptor Program. I am familiar with all of its ramifications and agree to abide by the Programs' requirements. I understand that the participating field doctor has read and signed a separate statement and has set aside any and all responsibility and/or liability of Palmer College of Chiropractic's West Campus.

While enrolled in the West Campus Program I will perform only those procedures which have been deemed legal and ethical by the California State Board of Chiropractic Examiners or appropriate governing/licensing authority of the state in which the Preceptor Program is being performed.

Upon entering into the Program, I agree to hold harmless Palmer College of Chiropractic, the West Campus, the West Campus Clinics, the Palmer Chiropractic Board of Trustees, Faculty, Administration, and Employees in any actions that may arise from the practice within the Preceptor's office(s), and while traveling to and from that office, in which I am working.

I understand that enrollment in this Program or payment of fees does not constitute a contract beyond any single term.

I agree to not present myself as a licensed doctor of chiropractic and to wear a name tag while working in the office identifying myself as an Intern or Preceptee.

Intern Signature: _____ Date: _____

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Field.training@palmer.edu

POSTGRADUATE PRECEPTOR PROGRAM PC521

INTERN AFFIDAVIT

1. I have read and received a copy the Preceptor Program Guidelines and am aware of the duties I am allowed to perform as an Intern in the West Campus Preceptor Program.
2. I have read the State Law rules and regulations for the state in which I intend to do my Postgraduate Preceptorship and understand those laws affecting Preceptorship.
3. I agree to abide by the rules and regulations set forth by State law and Palmer College of Chiropractic's West Campus policy while I am an Intern. I further agree that I will refuse to perform duties outside of the State Law or Palmer's West Campus policy and that I will report to the College any requests by the preceptor that would violate State Law or Palmer's West Campus policy.
4. I understand that violation of the State law or West Campus policy could result in my immediate termination from the Program.
5. I agree to submit to the Director of the Preceptorship Program all required reports and fees by published due dates.
6. I understand that failure to re-register for subsequent terms by the stated deadline (via written notification) will result in my termination from the program.
7. I understand that I may not begin to provide patient care under this program until I have received written or verbal communication from the program director that I may do so.

Intern Signature: _____ Date: _____

Palmer College of Chiropractic's West Campus
90 East Tasman, San Jose, CA 95134
Phone (408) 944-6036
Fax (408) 944-6093

POSTGRADUATE PRECEPTOR PROGRAM PC521

PATIENT ACKNOWLEDGEMENT FORM

*Please have all patients receiving care from
the Intern complete and sign this form*

I, (Patient's Name) _____ a patient at
(Office Name) _____ am aware that
(Intern's Name) _____ is an unlicensed,
graduate chiropractic Intern assigned to this office through an
approved Preceptorship program regulated by Palmer College of
Chiropractic's West Campus. I acknowledge the Intern's unlicensed
status and consent to receive care from him/her under the direct
supervision of Dr. _____ (Preceptor's Name).

Patient's Signature

Date

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POSTGRADUATE PRECEPTOR PROGRAM PC521

Verification of Completion

The Intern is responsible to have this form completed prior to being authorized to participate in the Preceptor program. This form will be sent to the State Board to verify that the Intern and the field doctor are properly participating in the program.

Please have this form signed by the appropriate office and submit it to the Director of the Preceptor program.

Intern's Name _____ Date _____

Present Street Address _____

Tele # (_____) _____ Fax # (_____) _____

Graduate of _____ Date _____

Doctor's Name _____

Office Address _____

Tele # (_____) _____ Fax # (_____) _____

Intern:

I have registered, submitted all required forms and fees to participate in this Preceptor Program.

Intern Signature: _____ **Date** _____

Doctor:

I have submitted all required fees and forms, including current and valid Chiropractic License, Malpractice policy and X-ray certificate, to participate in this Preceptor Program.

Doctor Signature _____ Date _____

OFFICIAL USE ONLY:

Registrars office:

The above named Intern has registered for course # PC 521. This is the (circle one) 1 2 3 4 time.

Registrars Signature _____ Date _____

Business office:

The above named Intern has paid for course # PC 521. \$ 225.00 Yes _____ No _____

Business Office Signature (or fund recipient) _____ Date _____

Director of Preceptor Program:

The above Intern and doctor have all required forms completed and on file. The doctor has provided their current and valid, Chiropractic License, Malpractice Policy and X-ray certificate.

Both the Intern and doctor are able to participate in the Preceptor Program for one quarter. In order to continue this program for up to 4 consecutive quarters, a new and updated "Verification of Completion" form will be required. If a new form is not submitted prior to the next quarter, both the Intern and the doctor voluntarily withdraw from the Preceptor Program.

Director of Preceptor Program Signature _____ Date _____