

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

INTERN/PRECEPTEE APPLICATION PACKET

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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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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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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: _____

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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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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 _____