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

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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.

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

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

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

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

[ ] Diversified	[ ] Gonstead	[ ] Activator
[ ] Thompson/Drop	[ ] Cox/Flexion-Traction	[ ] Biomechanics/CBP
[ ] Pettibon	[ ] ART/Soft-Tissue	[ ] SOT
[ ] Upper Cervical	[ ] Other:	[ ] 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:

_____ Adjusting rooms	_____ Total number
_____ Reception/Office	_____ Physical Therapy
_____ Other	_____ Doctors office/consultation
	_____ 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**

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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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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

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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) _____ 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