

# PALMER COLLEGE OF CHIROPRACTIC INTERN PRECEPTORSHIP PROGRAM

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## Field Doctor Application Checklist

**Notice! Doctors only need to apply to one of the three Palmer campus preceptor programs. Upon approval, your application is approved for all three campuses.**

1. [ ] Prior to completing the application, please review the program handbook. A current copy may be viewed at <http://www.palmer.edu/precept>.
2. [ ] Read the Palmer institutional policies found at <http://www.palmer.edu/HandbookPolicies/>
3. [ ] Print and complete the application.
4. [ ] Sign and date the application on the bottom of the last page.
5. [ ] Gather the following documents –
  - Copy of current chiropractic license (copy with expiration date)
  - Copy of current malpractice insurance (declaration page only)
    - A minimum policy limit of \$1,000,000/\$3,000,000 is required
  - California DC's – copy of current x-ray operator and supervisor's license
6. [ ] Requesting transcripts – If you are a graduate of a Palmer campus, please complete and sign a transcript request form (provided on last two pages of this application).

If you are a graduate of any other chiropractic college, please contact your college's registrar to request that your chiropractic college transcripts be sent to the Palmer Clinic Capstone Programs office. The mailing address is provided below.

**Return the following items to Clinic Capstone Programs at the address noted below:**

- \_\_\_ All pages of this application
- \_\_\_ Copy of current chiropractic license (copy with expiration date)
- \_\_\_ Copy of current malpractice insurance – declaration page only
- \_\_\_ Copy of current x-ray operator and supervisor's license if practicing in California
- \_\_\_ Completed and signed transcript request form (if a Palmer alumnus)

**Mail to:**

Palmer College of Chiropractic  
Attn: Clinic Capstone Programs  
1000 Brady Street  
Davenport, IA 52803

Or, email to: [sonya.willers@palmer.edu](mailto:sonya.willers@palmer.edu) or, fax to: 563-884-5822

Palmer College of Chiropractic  
**PRECEPTOR APPLICATION**

**APPLICANT INFORMATION**

Application Date:

Doctor's Full Legal Name:

Office Address (Not a PO Box):

Mailing Address (Can be a PO Box):

City:

State:

Zip Code:

Office Phone #: (      )

Office Fax #: (      )

Office Website Address:

Doctor's Email Address:

Second office address if applicable:

City:

State:

Zip Code:

Doctor's Date of Birth: Month\_\_ \_\_ Day\_\_ \_\_ Year \_\_ \_\_ \_\_ \_\_

Are you a current or past employee of any Palmer College of Chiropractic campus?     Yes     No

Office Hours at Primary Office Location:

Monday Start-End (eg 8 – 6:00)	Tuesday Start-End (eg 9 – 5:00)	Wednesday Start-End (eg 9 – 6:00)	Thursday Start-End (eg Closed)	Friday Start-End (eg 10 – 7:00)	Saturday Start-End (By appt)

Total number of practice hours per week: \_\_\_\_

**APPLICANT EDUCATION**

Chiropractic College Awarding D.C. Degree:

Chiropractic College City and State:

Mo. & Yr. Graduated:

Other College Degrees:

Chiropractic or Other Post-Graduate Residencies:

Chiropractic or Other Specialty Certifications:

**PRACTICE INFORMATION**

Practice Type:     Solo Chiropractic     Group Chiropractic     Group Multidisciplinary     Hospital

Number of Non-D.C. Employees/Office Staff:

Full-Time:

Part-Time:

Number of D.C. Employees or Partners:

Full-Time:

Part-Time:

Number of Other Health Professional Employees or Partners:

Office Square Footage:

# of Treatment Rooms:

Average Number of Patient Visits Per Month:

Number of New Patients Per Month:

Describe Patient flow in the Office:     High volume     Moderate volume     Low volume

Practice Management Company, if any:

Method(s) Used for Recording Patient Visits:

Name of Electronic Health Records Program:

Are you an approved Preceptor in another chiropractic college's program?     Yes     No

Do you prefer being contacted by email or phone?     Email     Phone     Either

Classify your office's scope of practice:     Broad     Moderate     Narrow

Your emphasis on chiropractic philosophy is:     Strong     Moderate     Low

Palmer College of Chiropractic  
**PRECEPTOR APPLICATION**

**FOR THE FOLLOWING SECTIONS, CHECK ALL THAT APPLY**

Primary Practice Model:

- General Practice
- Sports
- Workers Compensation
- Personal Injury
- Pediatrics
- Other; Describe: \_\_\_\_\_

Billing and Insurance:

- Cash practice only
- Insurance accepted
- # of insurance contracts \_\_\_\_\_
- Billing done by in-office employee(s)
- Billing outsourced
- Medicare accepted
- Other – Explain: \_\_\_\_\_

Patient Care Protocols You Use in Practice:

- Case History
- Physical Examination
- Orthopedic Evaluation
- Neurological Evaluation
- Diagnostic Imaging Studies – Plain Film X-ray
- Diagnostic Imaging Studies – Digital X-ray
- Report of Findings
- Informed Consent
- Posture Analysis
- Other (describe): \_\_\_\_\_

Check All Adjusting Techniques You Use:

- Gonstead
- Diversified
- Thompson/Drop
- Cox/Flexion – Traction
- Pettibon
- Upper Cervical
- Blair
- NUCCA
- Atlas Orthogonal (AO)
- Activator
- SOT
- Logan Basic
- Biomechanics/CBP
- Other: \_\_\_\_\_

Ancillary Procedures Provided in Your Practice:

- Heat / Ice
- Electric Modalities (US, MNS, EMS, etc.)
- Cold Laser
- Graston Technique
- ART (Active Release Therapy)
- Myofascial Release Therapy
- Surface EMG
- Other (describe): \_\_\_\_\_

*Please do not abbreviate*

\*\*Of the above adjusting techniques, which one do you use most often?

Does your office have rehabilitation equipment?  Yes  No

If yes, please describe:  High tech  Low tech  Frequently used  Occasionally used

Diagnostic Imaging used in your practice :

- Most new patients are x-rayed in-office using standard x-ray equipment.
- Most new patients are x-rayed in-office using digital technology.
- Most new patients are referred to a local diagnostic imaging center for films.
- The need for x-rays is determined on a case-by-case basis.
- Patients are occasionally referred for MRI studies.
- My films are read by a certified chiropractic radiologist.
- My films are read by a certified medical radiologist.
- I apply technique-related line drawings to my films.

X-ray unit certificate number: \_\_\_\_\_ Expiration date: \_\_\_\_\_ X-ray

operator's license number: \_\_\_\_\_

Palmer College of Chiropractic  
**PRECEPTOR APPLICATION**

**CHIROPRACTIC LICENSURE**

List ALL States in which you are currently licensed and have held a license in the past .  
Please include any additional states of current or past licensure on a separate piece of paper.

State:	License #:	Date Originally Issued:	Expiration Date:

Countries outside the U.S. you are authorized to practice in:

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

Are you currently facing, or ever been subject to, action by a state chiropractic board?       Yes    No

Are/were any of your current or expired license(s) encumbered in any way?       Yes    No

Have you had any formal disciplinary action or been a party to a malpractice settlement or judgment within the past three (3) years?       Yes    No

Are you currently a named defendant in a malpractice case?       Yes    No

Have you ever been convicted of a crime?       Yes    No

Please use this section to remark on any item above that you checked as "yes."

**PROFESSIONAL LIABILITY INSURANCE**

Carrier Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Dates of Coverage: From: \_\_\_\_\_ To: \_\_\_\_\_

Policy Limits: Per Occurrence: \$ \_\_\_\_\_ Aggregate: \$ \_\_\_\_\_

Are you currently a defendant in a malpractice claim(s)?       Yes       No

If yes, please explain:

**GROUP PRACTICE AGREEMENT**

If you work in a group practice that may require a formal agreement between Palmer College of Chiropractic and your facility in order to allow for student training, please provide the name and contact information of your organization's point person.

Not applicable

Yes, a formal agreement will be required. The point of contact is:

Name:

Email:

Phone:

Palmer College of Chiropractic  
**PRECEPTOR APPLICATION**

**1. STATEMENT OF UNDERSTANDING AND AGREEMENT**

I have read the provisions of the Palmer College of Chiropractic Intern Preceptorship Program as outlined in the program handbook. I understand and agree with the educational objectives contained therein and my role as an Extension/Adjunct Faculty mentor to an assigned student intern approved by Palmer College of Chiropractic to participate in my office. I am knowledgeable of the rules in my state, province, or country regarding the practice of chiropractic and applicable limitations for student interns. Student interns participating in my office will perform only those duties or services deemed ethical and legal in my state, and for which they have completed formal training at the College. I agree to be physically present on the same premises and be readily available to the student intern and my patients at all times when a student is performing any chiropractic service as allowed by state law and delegated by me. I agree to maintain my chiropractic licensure and malpractice insurance policy throughout the entirety of a preceptorship and will notify the College preceptor program director if either should lapse during the preceptorship time period. I further agree to notify the College preceptor program director immediately if I should come under disciplinary action by my state licensing board or be named a defendant in a malpractice suit during the preceptorship time period. I agree to sign a contract with Palmer College of Chiropractic instating me as an Extension or Adjunct Faculty Member when an intern is assigned to me. I understand that as the contracted Extension or Adjunct Faculty Member, I am responsible for supervising the intern and may not delegate supervision of the intern to another person within my practice or outside of my practice. I agree to notify the College preceptor program director if I have a change of office address or phone number or if I should elect to withdraw from the college's preceptor program. I understand this agreement to be binding in its terms as long as I remain an active participating preceptor for Palmer College of Chiropractic.

**2. STUDENT INTERN RESTRICTIONS REGARDING FEDERAL ENTITLEMENT PROGRAMS**

As stated in the program handbook, I understand and agree that student interns assigned to me will not be allowed to provide any chiropractic services to patients receiving Federal entitlement healthcare benefits such as Medicare and Medicaid. This restriction will include all aspects of patient care including but not limited to taking a health history, examining, and performing adjusting procedures.

**3. INSTITUTIONAL POLICIES**

I have reviewed the Palmer College of Chiropractic institutional policies on the College website at <http://www.palmer.edu/HandbookPolicies/> and understand and accept that institutional policies apply to me in my role as extension/adjunct faculty and to students participating in a preceptorship.

**AGREEMENT AND AUTHORIZATION**

By my signature below:

1. I indicate my understanding and agreement with the information provided in the handbook for the Intern Preceptorship Program including rules reiterated in this application, items 1 – 3 above.
2. I declare that the information contained in this application is true and accurate.
3. I understand that Palmer College will verify the information provided on this application and that my professional information on State Chiropractic Board website(s) and CIN-BAD will be checked.
4. I understand that Palmer College will check the following public U.S. Federal government exclusions lists to determine if I am in an excluded status : OIG (Office of the Inspector General), SAM (System for Awards Management) , and SDN (Specially Designated Nationals) .
5. I agree to complete Palmer College required training on an annual basis and understand that I will not be assigned a student unless my training is current.
6. I acknowledge that Palmer College reserves the right to deny an application and its decision in the matter will be considered final.

Signature of Applicant

Date

Printed Name of Applicant

**PALMER COLLEGE OF CHIROPRACTIC  
REGISTRAR'S OFFICE - TRANSCRIPT REQUEST  
FORM**

**Davenport Campus**  
1000 Brady Street  
Davenport, IA 52803  
Phone: (563) 884-5863  
Fax: (563) 884-5864

**West Campus**  
90 E. Tasman Drive  
San Jose, CA 95134  
Phone: (408) 944-6065  
Fax: (408) 944-6196

**Florida Campus**  
4777 City Center Parkway  
Port Orange, FL 32129  
Phone: (386) 763-2781  
Fax: (386) 763-2635

- Complete the form (PRINTING LEGIBLY) and return it to the appropriate campus address listed above.
- Select the type of transcript request.
- Provide us with any other materials necessary for individual State Board requests.
- Select a method of transcript disbursement.
- Select a method of payment. All documents being requested by fax must be paid for by a credit card number.

**MY PERSONAL STATUS:**

D.C. ALUMNI \_\_\_ B.S. ALUMNI \_\_\_ A.S.C.T. \_\_\_ ALUMNI \_\_\_ M.S. ALUMNI \_\_\_ FORMER STUDENT (Not a graduate)  
\_\_\_ CURRENT D.C. STUDENT \_\_\_ CURRENT A.S.C.T. STUDENT \_\_\_ CURRENT B.S. STUDENT \_\_\_ CURRENT M.S. STUDENT

NAME \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ GRADUATION DATE OR CLASS \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_ MATRIC # \_\_\_\_\_

SIGNATURE \_\_\_\_\_ S.S.N. # \_\_\_\_\_

**TRANSCRIPT REQUEST: (Please provide us with any additional forms requested by individual State Boards)**

\_\_\_ The State Board of Chiropractic for the State(s) of \_\_\_\_\_ (we have all addresses)

\_\_\_ The following Third Party receiving the transcript (school, business, etc.) \_\_\_\_\_

Third Party address \_\_\_\_\_

Myself: OFFICIAL DOUBLE SEALED transcript which I will forward to \_\_\_\_\_

\* Must be addressed to the third party who will be the final recipient of the transcripts. Requests will not be completed without this information.

\_\_\_ Myself: UNOFFICIAL copy for own personal use (NOTE: also available through Campus Connect for current students)

\_\_\_ Please mail transcript NOW

\_\_\_ Please mail transcript upon completion of current term of enrollment

Clinic Capstone Programs (fee waived)

**METHOD OF DISBURSEMENT:**

\_\_\_ Transcripts are sent U.S. mail at no additional cost.

\_\_\_ UPS Next Day Air or USPS Express Mail is available, with actual costs being calculated and charged at shipping time. **We are unable to ship next day to P.O. Boxes.**

For international next day shipments, please provide phone number of destination recipient: \_\_\_\_\_

**METHOD OF PAYMENT RECEIVED:**

Transcripts for scholarships or doctors applying to the preceptor program are processed free of charge.

\_\_\_ \$5.00 per transcript \_\_\_ (Number of transcripts requested) = \$ \_\_\_\_\_ TOTAL