PALMER COLLEGE OF CHIROPRACTIC
INTERN PRECEPTORSHIP PROGRAM

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 or julie.schrad@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): _____

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):_____

Check All Adjusting Techniques You Use:
[ ] Gonstead
[ ] Diversified
[ ] Thompson/Drop
[ ] Cox/Flexion – Traction
[ ] Pettibon
[ ] Upper Cervical
[ ] Blair
[ ] NUCCA
[ ] Atlas Orthogonol (AO)
[ ] Activator
[ ] SOT
[ ] Logan Basic
[ ] Biomechanics/CBP
[ ] Other: _____
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 LEGIBILY) 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:

__**X**_ 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

__**X**___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:

__**X**_Transcripts for scholarships or doctors applying to the preceptor program are processed free of charge.
_____$5.00 per transcript _____ (Number of transcripts requested) = $_____ TOTAL

_____Call (numbers above) for expense of UPS Next Day Air or USPS Express Mail $_____TOTAL
_____ CASH _____ CHECK _____ MONEY ORDER

_____ CREDIT CARD #_____ EXPIRATION DATE _____

NAME ON THE CREDIT CARD_____ CDC # (3 digits) _____

ADDRESS OF CARD HOLDER IF OTHER THAN ADDRESS ABOVE _____

_____ _____

Please allow two weeks from request received date to the designated destination date (except for Next Day Air or Express Mail requests).