



## PRECEPTOR APPLICATION CHECKLIST

Doctor: \_\_\_\_\_ City: \_\_\_\_\_

Thank you for your interest in the University of Western States Preceptorship Program.  
Please **MAIL** the following items along with your application:

- Preceptor Application Checklist (2 pages)
  - Preceptor Program Application (3 pages)
  - Preceptor Profile (1 page)
  - Copy of current chiropractic license
  - Current curriculum vitae
  - Current business card
  - Copy of current declaration of malpractice insurance
  - Claims History Authorization (1 page)
  - Copy of current x-ray supervisor and operator license (if applicable)
  - Copy of current yellow page ad and/or website address: \_\_\_\_\_
  - TWO redacted (HIPAA compliant) patient files (copies okay)**
    - One file needs to be of a newer patient (at least 8 visits)
    - One file needs to be of a patient that has been under your care for more than four months (at least 8 visits)
- Both patient files need to include the following items:
- Patient Intake Forms (including an Informed Consent form)
  - History
  - Examination (including appropriate neuro/ortho testing)
  - Diagnosis
  - Case Management
  - Re-Examination (timely re-evaluation)
  - X-ray and lab reports (internal and external)
  - Daily treatment notes

***If the application is not completed in its entirety or any of the requested attachments are omitted, the processing of your application will be delayed until everything is complete.***

The original application and documents are to be mailed to:

**Amber Smith**

Administrative Assistant for Clinical Internship  
University of Western States  
2900 NE 132<sup>nd</sup> Avenue  
Portland, OR 97230

Faxed documents will not be processed. Partial applications cannot be processed.  
If application is not addressed correctly, it may delay the delivery process since there are many different departments on campus; thank you.

1. Name of the UWS student interested in participating in the preceptor program in your office (if any):

\_\_\_\_\_

2. If you don't currently have an intern interested in a preceptorship with you, how did you hear about our program?

\_\_\_\_\_

3. Please note any planned vacation time you will have in the near future:

\_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_ to \_\_\_\_\_

4. Your regular patient care hours, not clinic hours (please include lunch break times):

	Hours:	Lunch:
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Notes:		

If your office is not open a minimum of 27 hours a week, you may not be eligible to participate in the preceptorship program.

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have any questions regarding the application or requested documents, please call Amber Smith, Administrative Assistant for Clinical Internship, at 503-251-2823 or email at [preceptor@uws.edu](mailto:preceptor@uws.edu).



PRECEPTOR PROGRAM APPLICATION

APPLICANT INFORMATION			
Name:			Date:
Office Address:			
City, State, Zip:			
Nearest Cross Street:			
Office Phone:		Fax:	
Email Address:		Website:	
Satellite Office Address:			
City, State, Zip:			
Office Phone:		Fax:	
Malpractice Insurance Carrier:			Expiration Date:
DC License #:	Date initially issued:	Expiration Date:	
Have you ever had your license suspended or revoked in your current or any other state?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently facing, or have you ever been subject to action by a state board?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted of a crime?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had any formal disciplinary action or been a party to a Malpractice settlement or judgment?			<input type="checkbox"/> Yes <input type="checkbox"/> No
APPLICANT EDUCATION			
Chiropractic College/Alma mater:			
Graduation Date:			
Other Degrees and College:			
Chiropractic or Other Post-Graduate Residencies:			
Chiropractic or Other Specialty Certifications:			
Did you participate in a preceptorship as a Chiropractic student?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have professional CPR/AED/First Aid certification?			<input type="checkbox"/> Yes <input type="checkbox"/> No Expiration Date:
PRACTICE INFORMATION			
Average number of patient visits per week:		Average number of new patients per week:	
Techniques used in practice. Please estimate the percentage.			
Activator		Diversified	
Applied Kinesiology		Extremity Adjusting	
ART		Flexion/Distracton	
CBP		Gonstead	
Cranial Adjusting		Graston	
		Logan Basic	
		Thompson	
		SOT	
		Upper Cervical	
		Other:	
Indicate the following therapies used in your office (check all that apply)			
Acupuncture		Massage therapy	
Bracing/lumbar support/cervical collar, etc.		Naturopathy	
Casting or athletic taping/strapping		Nutritional counseling, therapy or supplements	
Elec. Stimulation/TENS/high-volt/low-volt/EMS/IF		Physiotherapy Modalities	
Foot orthotics or heel lifts		Rehab or therapeutic exercise	
Homeopathy		Traction	
LASER- please list type:		Other:	

How do you determine where you are going to adjust?

What do you feel you have to offer UWS interns in your practice?

What percentages of patients in your practice are: Managed Care\_\_\_\_\_ Medicare\_\_\_\_\_ Cash\_\_\_\_\_ Personal Injury\_\_\_\_\_ Workers' Compensation\_\_\_\_\_ Medicaid/State\_\_\_\_\_ Other Insurance\_\_\_\_\_

Estimate the percentage of patients in your practice that are: Male\_\_\_\_\_ Female\_\_\_\_\_ Pregnant\_\_\_\_\_ Under 6 years old\_\_\_\_\_ 6 - 17 years old\_\_\_\_\_ 18 - 54 years old\_\_\_\_\_ 55+ years old\_\_\_\_\_

Please describe the three most common reasons you take x-rays:  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_

What percentage of your new patients under the age of 55 do you x-ray:

Are full spine x-rays taken for anything other than scoliosis screenings?  Yes  No  
 If yes, please explain purpose:

How soon, if ever, after initial x-rays are taken do you retake them for progress checks?

How do patients access you in an emergency?

HIPAA compliant?  Yes  No Notice of Privacy Practice Displayed?  Yes  No

Is patient communication done through social media or email?  Yes  No

**OFFICE INFORMATION**

Office square footage:\_\_\_\_\_ Number of Examination Room(s)/Treatment Room(s):\_\_\_\_\_/\_\_\_\_\_

Adjusting tables:  Flat Bench  Drop table  Flexion/Distracton  Axial traction  Hi/Lo  Knee/Chest

Rehab area or equipment available:  Yes  No Type: \_\_\_\_\_

Electronic Health Records:  Yes  No Software Name: \_\_\_\_\_

Electronic Billing:  Yes  No Company Name: \_\_\_\_\_

Professional/Licensed Staff:

Last Name	First Name	DC	MD	CMT/LMT	LaC	ND	Other

Ancillary/Support Staff: Front Office  Yes  No #\_\_\_\_\_ Back Office  Yes  No # \_\_\_\_\_

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: \_\_\_\_\_ Certificate expiration date: \_\_\_\_\_

By initialing the following, you agree that the statements herein below are true and accurate, or the best of your knowledge:

Initials	Statement
	As a preceptor/postceptor doctor, I am committed to being on the premises at all times the intern/extern is on the premises.
	I certify that I am not using any form of a “Pre-Paid Fee for Service Agreements”.
	I agree to comply with all relevant laws regarding the practice of chiropractic in my jurisdiction.
	I understand that all patients served in my health center must receive a consultation/history, physical examination, applicable orthopedic, neurologic, and chiropractic evaluation, a diagnostic conclusion, and a management plan.
	I authorize UWS to access CIN-BAD/national practitioner and state or provincial board data bases to verify my legal right to practice in the jurisdiction for which I am applying for preceptor status.
	I agree to notify UWS in writing within 72 hours of any accusation filed against my license. Failure to do so will result in immediate termination from the program.
	I understand that preceptor students may not represent themselves or be referred to by the doctor or any staff, as a doctor, D.C. or chiropractor, verbally or in written form.
	I have reviewed the UWS Doctor of Chiropractic Preceptor Program Manual and agree to abide by all terms and guidelines outlined therein.

\_\_\_\_\_

Doctor’s Signature

\_\_\_\_\_

Date

Comments:




## Preceptor Profile

Dear Doctor:

In an effort to continually upgrade our Preceptorship program and open the communication lines between the doctors and interns, we ask that you complete the following Profile which will be placed in a data base from which our interns search for potential Preceptorship faculty.

UWS reserves the right to remove words, or phrases that may negatively impact or reflect on the mission or goals of the University of Western States.

Doctor's Name: \_\_\_\_\_

Location (City/Clinic): \_\_\_\_\_

1. Primary techniques utilized: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Focus of practice: \_\_\_\_\_

\_\_\_\_\_

3. Languages spoken in practice: \_\_\_\_\_

4. Languages of benefit for intern to speak: \_\_\_\_\_

5. What can you offer an intern? \_\_\_\_\_

\_\_\_\_\_

6. What is expected of an intern? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DC Printed Name

DC Signature



### CLAIMS HISTORY AUTHORIZATION

To (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> National Chiropractic Mutual Insurance Co.<br>PO Box 9188<br>Des Moines, IA 50306                                      | <input type="checkbox"/> Gulf Insurance/OUM<br>125 Broad St., 7 <sup>th</sup> Floor<br>New York, NY 10004           |
| <input type="checkbox"/> Canadian Chiropractic Protective Association<br>802 The Queensway<br>Etobicoke, Ontario M8Z 1N5 Canada                 | <input type="checkbox"/> College of Chiropractors of Alberta<br>11203 - 70 Street NW<br>Edmonton, AB T5B 1T1 Canada |
| <input type="checkbox"/> College of Chiropractors of British Columbia<br>900-200 Granville Street<br>Vancouver, British Columbia V6C 1S4 Canada | <input type="checkbox"/> Medical Professional Liability<br>Agency 2, Depot Plaza<br>Bedford Hills, NY 10507         |

Other, please print all information below clearly:

Carrier Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_ Address: \_\_\_\_\_  
 Policy Number (if applicable): \_\_\_\_\_

I hereby authorize you to release a claims history to:

**Amber Smith**  
 Administrative Assistant for Clinical Internship  
 University of Western States  
 2900 NE 132<sup>nd</sup> Avenue  
 Portland, OR 97230

\_\_\_\_\_  
 Doctor Signature Date

\_\_\_\_\_  
 Name Printed Phone

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City, State, and Zip

# Intern Case File Review

## UWS Preceptor Program

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Prior to participating in the treatment of any patient, interns must review each patient's file and familiarize themselves with the following details:

1. Current and past **history**.
2. Initial and **subjective complaints**.
3. Initial and re-exam **diagnostic findings**.
4. Current **diagnosis**.
5. **Contra-indications** to any treatment, or potential treatment that may be utilized while the patient is under care.
6. **Treatment** - including the following:
  - Adjustments/Manipulations - specific levels.
  - P.T. modalities - type, location, duration, intensity.
  - Active care.
  - Frequency of treatment.
7. **Patient response** to current treatment regime - noted progress, or lack of progress.