UNIVERSITY of Western States

8000 NE Tillamook St • Portland, OR 97213

Campus Health Center • Phone: 503-255-6771
Administration Fax: **503-251-2837**
www.uws.edu

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:

Preceptor Coordinator
University of Western States
8000 NE Tillamook St
Portland, OR 97213

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 the Preceptor Coordinator at 503-251-2823 or email at preceptor@uws.edu.

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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? ☐ Yes ☐ No		
Are you currently facing, or have you ever been subject to action by a state board? ☐ Yes ☐ No		
Have you ever been convicted of a crime? ☐ Yes ☐ No		
Have you ever had any formal disciplinary action or been a party to a Malpractice settlement or judgment? ☐ Yes ☐ 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? ☐ Yes ☐ No
Do you have professional CPR/AED/First Aid certification? ☐ Yes ☐ 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		Logan Basic	
Applied Kinesiology		Extremity Adjusting		Thompson	
ART		Flexion/Distraction		SOT	
CBP		Gonstead		Upper Cervical	
Cranial Adjusting		Graston		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/Distraction ☐ 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, in written form, and/or digitally.
_____	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:

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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

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CLAIMS HISTORY AUTHORIZATION

To *(check all that apply)***:**

☐ **National Chiropractic Mutual Insurance Co. (NCMIC)**
PO Box 9188
Des Moines, IA 50306

☐ **Canadian Chiropractic Protective Association (CCPA)**
802 The Queensway
Etobicoke, Ontario M8Z 1N5 Canada

☐ **College of Chiropractors of British Colombia (CCBC)**
900-200 Granville Street
Vancouver, British Columbia V6C 1S4 Canada

☐ **Gulf Insurance / OUM**
125 Broad St., 7th Floor
New York, NY 10004

☐ **College of Chiropractors of Alberta (ACAC)**
11203 – 70 Street NW
Edmonton, Alberta T5B 1T1 Canada

☐ **Medical Professional Liability**
Agency 2, Depot Plaza
Bedford Hills, NY 10507

☐ **OTHER** (none of the above): please print all information below clearly:

Carrier Name: _____ Phone: _____
Address: _____ **FAX:** _____
_____ Policy Number: _____
_____ _____

I hereby authorize you to release a claims history to:

Preceptor Coordinator
University of Western States
8000 NE Tillamook St
Portland, OR 97213

_____ _____
Doctor Signature Date

_____ _____
Name Printed Phone

_____
Street Address

_____
City, State, and Zip

Intern Case File Review
UWS Preceptor Program

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.