# CLINICAL PRECEPTOR APPLICATION

**Application Checklist:**
***Application is complete when all listed materials are received.***

- ☐ Signed Application Form
- ☐ Copy of current professional state license
- ☐ Copy of policy cover page for current professional liability and malpractice insurance
- ☐ Copy of current DEA Registration Certificate (if applicable)
- ☐ Copy of CV

**Please send all application materials to the Manager of Clinical Education Programs:**


**Email:**
kpvisconti@westernu.edu

**Fax:**
ATTN: Mrs. Kelee P. Visconti
909-706-3905

**Mail:**
Western University of Health Sciences, College of Optometry
ATTN: Mrs. Kelee P. Visconti
309 E. Second Street
Pomona, CA 91761


***Thank you for your willingness to be a Preceptor and for taking time to complete this application.***

Western University of Health Sciences
College of Optometry

## SECTION I: PRECEPTOR INFORMATION

First Name: _____ MI: _____ Last Name: _____

___ Degree Institution: _____ Graduation Date: _____

E-mail Address: _____ Phone Number: _____

Residency Training: _____

Additional Certification or Training: *(such as diplomates, etc.)*

_____

Prior Teaching or Precepting Experience: _____

Current Academic Appointments: _____

Research Area of Interest: _____

**OPTIONAL INFORMATION: (Requested by accreditation bodies; providing this information will also assist us with surveys.)**

Doctor Ethnicity:

| | | | |
|---|---|---|---|
| White (Non-Hispanic) | ☐ | Hispanic | ☐ |
| Native American | ☐ | Multi-Ethnic | ☐ |
| Asian/ Pacific Islander | ☐ | Other | ☐ |
| Black | | | |

## SECTION II: SITE INFORMATION

Facility Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Office Phone: _____ Office Fax: _____

**Mode:**

☐ Private

- ☐ Solo
- ☐ Group

☐ Institutional

- ☐ Hospital / University
- ☐ IHS
- ☐ Military
- ☐ VA

☐ Commercial

☐ Other

* If GROUP, please indicate disciplines represented below: *(OD only, OD, MD, etc.)*

_____

* If OTHER, please specify below:

_____

Western University of Health Sciences College of Optometry

**Practice is Primarily: (***Please check all that apply)*

☐Contact Lens
☐Specialty/Medical CL Fitting
☐Primary Care

☐Rehabilitation
___ % Binocular/VT
___ % Neuro-Rehabilitation
___ % Low Vision
___ % Learning Disability

☐Surgery
☐ Refractive
☐ Other

☐Tertiary Care

**Student Education:**

Average expected patient encounters per week for student: _____

Applies to Externship only *(3rd & 4th year students)*

1. Will the student have his/her own exam lane? Choose an item.
2. Will the student be allowed full examination and patient management privilege (with supervision)? Choose an item.

**Opportunity is provided to:** *(please check all that apply)*

| | | |
|---|---|---|
| ☐ Observe in | ☐ Participate in | Glaucoma management |
| ☐ Observe in | ☐ Participate in | Injections |
| ☐ Observe in | ☐ Participate in | Laser procedures |
| ☐ Observe in | ☐ Participate in | Minor surgical procedures |
| ☐ Observe in | ☐ Participate in | Practice Management |
| ☐ Observe in | ☐ Participate in | Surgery or perioperative care |

How many days and hours per week will the student work?

| **Days** | **☐ Mon** | **☐ Tue** | **☐ Wed** | **☐ Thu** | **☐ Fri** | **☐ Sat** | **☐ Sun** |
|---|---|---|---|---|---|---|---|
| **Hours** | **___ to ___** | **___ to ___** | **___ to ___** | **___ to ___** | **___ to ___** | **___ to ___** | **___ to ___** |

How many offices will the student rotate through? _____

How many preceptors will the student work with (please provide names and specialty or degree):

Please describe the clinical and educational plans for the student. (Please indicate whether direct care or observation, types of patient encounters, amount of supervision and guidance, etc.)

## SECTION III: EQUIPMENT INFORMATION

The following Equipment is available: *(please check all that apply)*

- ☐ Threshold VF
  *Model:* _____
- ☐ FDT
- ☐ Pachymeter
- ☐ Goldmann Tonometer
- ☐ Tonopen
- ☐ Other Tonometer
- ☐ Ultrasound
- ☐ Fluorescein Angiography
- ☐ Manual phoropter
- ☐ Electronic phoropter
- ☐ Imaging/ Scanning
  *Type:* _____
- ☐ Topographer
- ☐ Keratometer
- ☐ Auto refraction
- ☐ Anterior Photo
- ☐ Fundus Photo
- ☐ Other: _____

Western University of Health Sciences College of Optometry

## SECTION V: FERPA & CONFIDENTIALITY AGREEMENT

***Family Educational Rights and Privacy Act of 1974***

*In your capacity as a Preceptor for Western University of Health Sciences, you have access to confidential student data. The data, its confidentiality, use, and release are governed by the Family Educational Rights and Privacy Act of 1974 (a.k.a., Buckley Amendment, FERPA). Your utilization of this information is governed by the regulations, duties and responsibilities of your appointment to this position. Your position and its access to student data place you in a position of trust. You are now an integral part in ensuring that student information is handled properly. Students have a right to expect that their academic and personal information are being treated with the care and respect that we would want for our own records.*

*All student information must be treated as confidential. Even public or "directory" information is subject to restriction on an individual basis. Any requests for disclosures of student information (contact information, attendance, etc.) or student progress (grades, performance evaluations, etc.) from any party other than the student or the instructor of record must be referred to the WesternU Registrar's Office.*

***Confidentiality***

***National Practitioner Databank (NPDB)*** *may be used to process your application. The NPDB is primarily an alert or flagging system intended to facilitate a comprehensive review of health care practitioner's professional credentials. The information contained in the NPDB is intended to direct discrete inquiry into specific areas of a practitioner's licensure, professional society memberships, medical malpractice payment history and record of clinical privileges. Information reported to the NPDB is considered confidential and shall not be disclosed except as specified in the NPDB regulations. The* ***Privacy Act of 1974****, protects the contents of Federal systems of records such as those contained in the NPDB from disclosure, unless the disclosure is for a routine use of the system of records as published annually in the Federal Register. The published routine uses of NPDB information do not allow for disclosure of Information to the general public.*

I hereby certify that the information on this application and all other information that I have otherwise provided is true and correct. I understand that any misrepresentation or omission will be sufficient cause for cancellation of this application or removal from the roster of Clinical Preceptors.

I have received and reviewed the American Optometric Association Code of Ethics.

I have received and reviewed the FERPA laws governing my role as preceptor.

I agree to give a minimum notice of one semester (3 months) should I choose to no longer participate as a Clinical Preceptor.

I hereby authorize Western University of Health Sciences, College of Optometry to verify the information provided in this Clinical Preceptor application through the National Practitioner Data Bank and the applicable California State Board.

I represent and warrant that I have read and fully understand the foregoing, and I seek a Clinical Preceptor appointment under these conditions.

Signature: _____ Date (MM/DD/YY): _____

**DO NOT RETURN THIS PAGE. PLEASE KEEP THIS DOCUMENT FOR YOUR RECORDS.**

American Optometric Association

## Code of Ethics

It shall be the ideal, resolve, and duty of all optometrists:

**TO KEEP** their patients' eye, vision, and general health paramount at all times;

**TO RESPECT** the rights and dignity of patients regarding their health care decisions;

**TO ADVISE** their patients whenever consultation with, or referral to another optometrist or other health professional is appropriate;

**TO ENSURE** confidentiality and privacy of patients' protected health and other personal information;

**TO STRIVE** to ensure that all persons have access to eye, vision, and general health care;

**TO ADVANCE** their professional knowledge and proficiency to maintain and expand competence to benefit their patients;

**TO MAINTAIN** their practices in accordance with professional health care standards;

**TO PROMOTE** ethical and cordial relationships with all members of the health care community;

**TO RECOGNIZE** their obligation to protect the health and welfare of society; and

**TO CONDUCT** themselves as exemplary citizens and professionals with honesty, integrity, fairness, kindness and compassion.