UAB SCHOOL OF OPTOMETRY

EXTERNSHIP SITE APPLICATION

The information on this form will be used to determine program eligibility and to assist students in the selection of their extern site. Your signature on the "Primary Preceptor Statement" at the end of this document indicates your approval to allow us to share this information with appropriate parties.

Date: _____

Name of Practice: _____

Address: _____
City: _____State:_____ Zip:_____
Phone #: _____FAX #: _____
Office Hours: _____
Owner(s) of Practice: _____
E-mail Address: _____Website: _____

Primary Preceptor: _____ Email Address: _____
Professional School: _____ Degree: _____
Graduation Year: _____ Residency Completed? _____
If yes, Residency Title/Specialty: _____
States currently licensed in: _____

Have you or anyone in your practice had any disciplinary action taken against you by your State Board of Optometry within the last five years? _____
If yes, please explain:

Secondary Preceptor: _____ Email Address: _____
Professional School: _____ Degree: _____
Graduation Year: _____ Residency Completed? _____
If yes, Residency Title/Specialty: _____
States currently licensed in: _____

Secondary Preceptor: _____ Email Address: _____
Professional School: _____ Degree: _____
Graduation Year: _____ Residency Completed? _____
If yes, Residency Title/Specialty: _____
States currently licensed in: _____

Secondary Preceptor: _____ Email Address: _____
Professional School: _____ Degree: _____
Graduation Year: _____ Residency Completed? _____
If yes, Residency Title/Specialty: _____
States currently licensed in: _____

Secondary Preceptor: _____ Email Address: _____
Professional School: _____ Degree: _____
Graduation Year: _____ Residency Completed? _____
If yes, Residency Title/Specialty: _____
States currently licensed in: _____

Practice Organization:
☐Solo (OD or MD) ☐Partnership (OD or MD)
☐OD Group ☐MD Group
☐Multidisciplinary Eye Care (OD &MD) ☐Institution
☐VA ☐IHS ☐ Military ☐Community Health Center
Other:_____

Type of Practice: Select description(s) that reflects main emphasis of practice:
☐Family Practice ☐ Primary Eye Care ☐Contact Lenses
☐ Geriatrics ☐Pediatrics ☐Sports Vision
☐ Low Vision ☐ Visual Training ☐ Developmental Vision
☐Ocular Disease ☐ Refractive Surgery ☐Neuro
Other: _____

Name of other optometric institutions this site has externship affiliations with:
_____

Number of UAB students the site can accept per rotation: _____

Maximum number of students at this site at any time from all optometric education institutions: _____

Based on the externship session and externship requirements, externship rotations may be 6 weeks, 8 weeks, or 16 weeks. Please select all of the rotation time lengths below that you are willing to host an extern.
☐ 6 weeks ☐ 8 weeks ☐ 16 weeks

Number of Exam Lanes:_____Does student have their own exam room? ☐Y ☐N
If not, how will space be provided to extern for direct patient care?_____

Specialty testing equipment available in your practice. Please check or note below:

☒Automated Perimeter ☐ A/B Scan ☐ Wide Field Imaging

☐ Anterior Segment Camera ☐Posterior Segment Camera ☐OCT

☐ Corneal Topographer ☐Pachymeter

Other specialty equipment:

Average number of patients visits per day: _____

Average number of patients that will be seen daily by student: _____

Can you provide the student with a minimum of 25 direct patient encounters per week?

☐Y ☐ N

If not, please elaborate:

Types of patients seen in your practice:

Primary Care	_____	%	Regular Contact Lenses	_____	%
Specialty Contact Lenses	_____	%	Pediatric	_____	%
Sports Vision	_____	%	Visual Training	_____	%
Low Vision	_____	%	Medical/Surgical	_____	%
Refractive Surgery	_____	%	Binocular Vision	_____	%
Neuro-Rehab	_____	%	Dry Eye	_____	%

Amount of time the student will spend per week in:

Direct patient care:	_____ %
Shared care:	_____ %
Observation:	_____ %
Telehealth:	_____ %
Scholarly activities:	_____ %
Technician duties:	_____ %

Will you or another approved preceptor be on the premises whenever externs are present? ☐ Y ☐ N

If not, please elaborate:

<u>Housing Information</u> (Pertains only to those practices beyond commuting distance from UAB.)

Is short-term housing available in your community for the extern? _____

Approximate cost if known_____

Are you willing to assist in making arrangements for accommodations for externs who will be residing outside of Birmingham proper?

1. **Please attach the CVs and current licenses of the primary preceptor and secondary preceptors in the practice that will be interacting with our students.**

2. **Please read and sign the "Preceptor Statement" on the next page.**

3. **A separate "Affiliation Agreement" initiated by the University (School of Optometry) or a "Memorandum of Understanding" initiated by the Facility (Externship Site) must be approved and signed by both parties prior to the assignment of any student.**

Primary Preceptor Statement

I, _____, hereby certify that I:
(FULL NAME)

1. am licensed by a State Board of Optometry or Medicine and a practitioner in good standing with the Board.

2. conduct my practice in accordance with the ethics and practice guidelines of my professional organization.

3. have read the externship Guidelines and agree to Preceptor's responsibilities as outlined.

4. agree to devote the necessary time to teach the extern.

5. understand that I am under no financial obligation to the student.

6. agree to evaluate the student justly and to complete the evaluation forms in a timely fashion.

7. understand that in the event that I will no longer be able to accept an extern, I will be allowed to withdraw from the externship temporarily or permanently upon written notice.

Signed_____

Date_____

Please return to:
Mrs. Cynthia Perry, Administrative Director
UAB School of Optometry
1716 University Blvd.
Birmingham, AL 35294-0010
(205) 934-2624 (Office direct) E-Mail- CMBB11@uab.edu