UNIVERSITY OF ALABAMA AT BIRMINGHAM
SCHOOL OF OPTOMETRY
Preceptor Application Form

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

Directions: Please answer each question completely.

Primary Preceptor Information

1. Name of Practice:_____

   Name of Primary Preceptor: _____ Degree: _____

   Address:_____

   City:_____State:_____Zip:_____

   Telephone:_(_____)_____FAX: (____)_____

   E-mail Address _____Website _____

2. Practice Organization: Please circle or note below organizational structure:
   Solo (Optometry or Ophthalmology), Partnership (Optometry or Ophthalmology), Optometry Group, Ophthalmology Group, Multidisciplinary Eye Care (Optometry & Ophthalmology), Multidisciplinary Health Care, VA, IHS, Military, HMO, Community Health Center

   Other:_____

3. Type of Practice: Please circle or note below, description that reflects main emphasis of practice:
   Family Practice, Primary eye care, Contact Lenses, Geriatric Optometry, Pediatric Optometry, Sports Vision, Low Vision, Visual Training, Developmental Vision, Ocular Disease, Refractive Surgery, Ocular Surgery

   Other:_____

4. Health professional school attended, degree and year received:

   _____

5. Post-graduate training, if applicable: _____

_____

(Question # 6 - For Doctors of Optometry only)

6. States in which you are currently licensed_____

Are you certified for the use of therapeutic drugs?_____ State_____

License # _____

7. Are you a preceptor for any other academic institutions?_____

If yes, which schools?_____

How many externs do you normally have per quarter? _____
Can you accept more than one extern from UAB? _____

Facility and Staffing Information

8. Office or Facility: Size:_____ sq. ft.
Number of Basic Exam Rooms:_____
Number of Auxiliary Testing Rooms and Types: _____

_____

_____

9. Will the extern have his/her own examination room? _____
If not, how will space be provided to extern for direct patient care?

_____

10. Type of Office Staff and number: Please circle or note below:
Technical:

Certified: CPOA _____, CPOT_____, COA_____, COT_____

Licensed Optician: _____ Certified Optician _____

Non-Certified: Optometric or Ophthalmic Assist., Tech. or Optician _____

Other Technical Support _____

_____

Non-Technical Support Staff

Management _____ Reception _____ Insurance_____

Other_____

Patient Care Information

11. Approximate average number of total patients visits per day (visits include full examinations, progress reports, etc.) _____

12. Approximate average number of office hours per week._____

13. Can you provide the student with a minimum of 25 hours per week of direct patient care experience?_____

14. Significant diagnostic equipment available in your practice that would help to augment an extern's clinical experience. Please circle or note below:
Automated Perimeter, Laser Interferometer, A-B Scan, Anterior Segment Camera, Posterior Segment Camera, Corneal Topographer, Pachymeter, OCT, HRT, OptiMap.

    Other: _____

    _____

15. Approx. percentage of patients who are dilated on a routine basis? _____%

16. On what percentage of patients do you use your Binocular Indirect Ophthalmoscope? _____%

17. On what percentage of patients do you use your Slit Lamp? _____%

18. Estimate the percentage of patients on whom gonioscopy is performed? _____%

19. Students will perform exams in a semi-autonomous mode what percentage of the time? _____%
    Pertinent comments _____

    _____

    _____

20. Do you provide pre-operative and post-operative care? _____

    If so, will the extern be able to participate in the pre-surgical evaluation and/or post-operative follow-up? _____

21. With the preceptor's approval, will the extern be able to help formulate and initiate a proper treatment plan? _____

22. With the preceptor's approval, will the extern be able to formulate his/her own plan for follow-up? _____

If even on a limited basis, is it possible for the extern to see the same patients who are on a continuing follow-up care plan? _____

23. Will you or another approved preceptor be on the premises whenever externs are present so as to observe them directly? _____

24. When not directly involved in patient care, will you be able to provide the extern with non-patient care activities?_____

What type of activities? _____

25. If this is an optometric office, do you co-manage with one or more ophthalmologists? _____

If yes, would the ophthalmologist(s) be willing to allow our student(s) to observe and interact? _____

Name of MD _____Phone # ___Email _____

Name of MD _____Phone # ___Email _____

Name of MD _____Phone # ___Email _____

26. If this is an ophthalmology practice, please list two to four O.D.'s that refer to you for co-management of patient care. Please include their phone numbers, including area code and email address.

Name _____Phone:___ Email _____

Name _____Phone:___ Email _____

Name _____Phone:___ Email _____

Name _____Phone:___ Email _____

27. If other optometrists and/or ophthalmologists in your office will be interacting with the extern(s), please list below: **Please submit their CVs.**

Name _____Degree_____ Email _____

Name _____Degree_____ Email _____

Name _____Degree_____ Email _____

Name _____Degree_____ Email _____

Name _____Degree_____ Email _____

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

28. 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?

_____

PLEASE ENCLOSE YOUR CV WITH THIS APPLICATION
(Also enclose CVs of other ODs and/or MDs in your practice that will be interacting with our students)

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

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 of my professional organization.

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

4. agree to devote the necessary time to teach the extern as I will be the chief source of clinical expertise for the extern.

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

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

7. understand that the Externship Program is perennial by design and I am prepared to accept an extern given suitable notification.

8. 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, Externship Administrative Assistant
UAB School of Optometry
HPB Room 307
1716 University Blvd.
Birmingham, AL 35294-0010
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Office Direct (205) 934-2624
FAX (205) 934-6758