PLEASE PRINT OR TYPE

OU-COM/CORE

PRECEPTOR INFORMATION FORM (PIF)
INTERNATIONAL CLINICAL ROTATIONS (ICR)

Date ________ Name ____ Degree ______________Gender _______
First Middle Initial Last Jr./Sr.

Specialty ______________________ DOB ____________ Social Security number _____________________
(For ID purposes)

Medical License number ___________________ Expiration date ______________

If board certified, list specialty:
____

Business Name:
____

Business Address (no P.O.)
____
Street City State Zip County

Do you carry malpractice insurance ☐ yes ☐ no Name of Insurance Company ___________________________

Amount of Malpractice coverage __________________ per occurrence ______________ aggregate
(May attach copy of malpractice face sheet)

Business telephone ______________________________ e-mail address ________________________________
Area Code Phone number

Home address ____
Street City State Zip County

Specify Type of Practice: (Check all that apply)
___ Solo, Private Practice
___ Group, Private Practice
___ Hospital
___ Office

Indicate Percentages of Practice:
___ % Medicaid
___ % Medicare
___ % Private/Commercial
___ % Charity
___ % Other _____________

Specify Practice Location:
___ Small Community ___ Inner City
___ Rural ___ Suburban
___ Urban

Specify Patient/Client Volume:
___ < 25/day ___ 50-75/day
___ 25-50/day ___ > 75/day

ETHNICITY (Optional):
___ White (non Hispanic) ____ Hispanic____ Black ____ Native American___ Asian/Pacific Islander

List anyone other than yourself who should be notified of a student's rotation (e.g. Med. Ed. Dept.):

Name/Title ____ **Phone** _______________________

EDUCATION

Medical Colleges/Graduate school | Date

Type of Internship completed | Name of Institution | Date

Type of Residency completed | Name of Institution | Date

Type of Residency completed | Name of Institution | Date

Type of Post-residency Training completed (e.g., Fellowships, etc.) | Name of Institution | Date

Type of Post-residency Training completed (e.g., Fellowships, etc.) | Name of Institution | Date

HOSPITAL AFFILIATIONS (active, consulting, courtesy, other):

Hospital Membership	Active	Consulting	Courtesy	Other
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Current and past teaching appointments:

Nationality

Briefly, check which CORE competencies* are covered in this rotation.

- ☐ **Osteopathic Principles and Practices**
- ☐ **Medical Knowledge**
- ☐ **Patient Care**
- ☐ **Interpersonal and communication skills**

(*See back of sheet for description)

- ☐ **Professionalism**
- ☐ **Practice-based learning and improvement**
- ☐ **Systems-based learning**
- ☐ **None of the above**

Name:

CORE COMPETENCIES*

Osteopathic Principles and Practices

- **demonstrate and apply knowledge of accepted standards in Osteopathic Manipulative Treatment (OMT)**
- **remain dedicated to life-long learning and to practice habits in osteopathic philosophy and manipulative medicine**

Medical Knowledge

- **demonstrate and apply knowledge of accepted standards of clinical medicine**
- **remain current with new developments in medicine**
- **participate in life-long learning activities, including research**

Patient Care

- **demonstrate the ability to effectively treat patients**
- **provide medical care that incorporates**
    - **the osteopathic philosophy**
    - **patient empathy**
    - **awareness of behavioral issues**
    - **preventive medicine**
    - **health promotion**

Interpersonal and communication skills

- **demonstrate interpersonal and communication skills that enable you to establish and maintain professional relationships with**
    - **patients**
    - **families**
    - **other members of health care teams**

Professionalism

- **uphold the Osteopathic Oath in the conduct of your professional activities that promote advocacy of patient welfare**
    - **adherence to ethical principles**
    - **collaboration with health professionals**
    - **life-long learning**
    - **sensitivity to a diverse patient population**
- **be cognizant of your own physical and mental health in order to effectively care for patients**

Practice-based learning and improvement

- **demonstrate the ability to critically evaluate your methods of clinical practice**
- **integrate evidence-based medicine into patient care**
- **show an understanding of research methods**
- **improve patient care practices**

Systems-based learning

- **demonstrate an understanding of health care delivery systems**
- **provide effective and qualitative patient care within the system**
- **practice cost-effective medicine**

Name:

DISCLOSURE INFORMATION

Please answer the following questions "yes" or "no". If your answer to questions 1-18 is "yes" or if your answer to question 19 is "no", please provide **a written explanation** on a separate sheet.

INSTRUCTION NOTE: A voluntary surrender or non-renewal is for reasons related to professional competence or conduct when the surrender or non-renewal is done to avoid an adverse action, preclude an investigation or is done while the licensee is under investigation related to professional competence or conduct.

	Question	Yes	No
1.	Have any of your board certifications or equivalents ever been suspended, revoked, voluntarily surrendered or have you failed to recertify?	☐	☐
2.	Has your professional license, in any jurisdiction, ever been voluntarily or involuntarily suspended, limited, revoked, denied, or surrendered or subjected to probationary conditions or are any such actions pending?	☐	☐
3.	Has your DEA license or state narcotics registration ever been voluntarily or involuntarily suspended, limited, revoked, denied, or restricted for reasons other than non-completion of medical records or are any such actions pending?	☐	☐
4.	Has your hospital or facility medical staff membership or have your hospital or facility professional privileges ever been voluntarily or involuntarily suspended, limited, revoked, denied or surrendered for reasons related to professional competence or conduct, other than non-completion of medical records or are any such actions pending?	☐	☐
5.	Have you ever been placed on probation or asked to resign an internship or residency-training program?	☐	☐
6.	Has Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed or terminated your participation for reasons related to professional competence or conduct?	☐	☐
7.	Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program?	☐	☐
8.	Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)?	☐	☐
9.	Have you ever been named as a defendant in any criminal case? (excluding minor traffic infractions, but not DUIs)	☐	☐
10.	Have you ever been convicted of a felony?	☐	☐
11.	Have you ever been disciplined for a violation of ethical standards by a professional organization? Name:	☐	☐
12.	To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐	☐

13. Do you have a history of engaging in the illegal use of drugs? ("Illegal use of drugs" means the use of any controlled substances illegally obtained, i.e. not obtained pursuant to a valid prescription and not taken in accordance with the direction of a licensed health care practitioner.) ☐ ☐

14. Are you currently engaged in the illegal use of drugs? ("Currently" does not mean on the day of or even the weeks preceding the completion of this PIF. Rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.) ☐ ☐

15. Are you currently in treatment for addiction to drugs or alcohol? ☐ ☐

16. Within the last five years, have you been reprimanded or disciplined in any manner by any state licensing authority or other professional board for conduct related to the use of alcohol or the use of any drug? ☐ ☐

17. Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic testing center, hospital, ambulatory surgery center, or other business dealing with the provision of ancillary health services, equipment, or supplies? ☐ ☐

18. Do you have any emotional or physical disabilities that may limit your ability to practice? ☐ ☐

19. Are you able to perform the procedures and the essential functions of the position for which you have applied or requested privileges, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients? ☐ ☐

This information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection.

____

Signature Date

Please submit PIF to:

Gillian H. Ice, Ph.D., M.P.H.
Director of International Programs
Ohio University College of Osteopathic Medicine
309 Grosvenor Hall
Athens, OH 45701
(0001) 740 593-1730 (fax)