KYCOM ADJUNCT CLINICAL FACULTY AFFILIATION AGREEMENT

Note:
In order to start an academic file for you at Kentucky College of Osteopathic Medicine, we will need you to complete and return the following items:

- ☐ **The attached adjunct clinical faculty affiliation agreement**
- ☐ **An updated copy of your curriculum vitae**
- ☐ **A face copy of your malpractice insurance**
- ☐ **A copy of your current medical license**

These items should be returned to:

Julie Stephens
Northeast KY AHEC
316 W. Second St., Suite 203
Morehead, KY 40351
Fax: 606-784-2767
E-Mail: julie.stephens@neahec.org

Jennifer Ratliff
KYCOM
147 Sycamore Street
Pikeville, KY 41501
Fax 606-218-5447

KENTUCKY COLLEGE OF OSTEOPATHIC MEDICINE

ADJUNCT CLINICAL FACULTY
AFFILIATION AGREEMENT

NAME: _____ ☐ D.O. ☐ M.D. Other _____

PRACTICE SPECIALTY: _____

BOARD CERTIFIED: ☐ YES ☐ NO ELIGIBLE: ☐ YES ☐ NO

PRIMARY OFFICE: _____

_____

_____

TELEPHONE NUMBER:

OFFICE: _____/_____/_____ HOME _____/_____/_____

FAX: _____/_____/_____ E-MAIL ADDRESS: _____

HOSPITAL STAFF APPOINTMENTS: _____

_____

STATE LICENSES: STATE_____ LICENSE #_____

STATE_____ LICENSE #_____

CURRENT MEDICAL
MALPRACTICE INSURANCE COMPANY_____

CERTIFICATE #_____

LIMITS _____/_____

MONTHS YOU WOULD "NOT" WANT STUDENTS: _____/_____/_____/_____/_____

****

FOR OFFICE USE ONLY:

PRIMARY CARE ROTATION ☐ **YES** ☐ **NO**

PRACTICE SPECIALTY _____

APPLICATION ACCEPTED ☐ **YES** ☐ **NO** **DATE** _____/_____/_____

FACULTY APPOINTMENT _____ **DATE** _____/_____/_____

CERTIFICATE ISSUED **DATE**_____/_____/_____

CURRICULUM ISSUED **DATE**_____/_____/_____

AFFILIATION AGREEMENT

This agreement with Kentucky College of Osteopathic Medicine (hereafter KYCOM) is to provide clinical training opportunities for the students, especially in the third and fourth year. With this affiliation, I seek appointment to the Adjunct Clinical Faculty. I understand that with the acceptance of the agreement, I will assist in providing clinical training for the osteopathic medical students. I agree to follow the curriculum provided by the clinical department at KYCOM. I will also agree to review, monitor, and provide feedback for the revision of the curriculum as needed.

Upon the completion of each individual training period, I will, within 30 days, fully complete and return to KYCOM the student evaluation form. I also understand that an evaluation of me will be required from each student who does a rotation with me. I understand that this is one part of the continual faculty evaluation process at KYCOM, and that I am encouraged to contact KYCOM regarding current, past, or future students, curriculum, or with any questions or comments regarding grading or training procedures.

With this agreement, I affirm that I am duly licensed to practice medicine and have current medical malpractice insurance. I will notify KYCOM immediately of any changes to my practice status. I agree to provide KYCOM with at least 90 days notice should I decide to voluntarily terminate this agreement. This agreement may be terminated without cause at any time by KYCOM. I understand that KYCOM will provide me in advance with a list of the students I will be asked to precept, and that I will be asked to approve the list prior to any changes in the approved schedule. I may, at my discretion, make needed changes in my availability for teaching by contacting KYCOM in writing prior to the change. I may refuse any student / students by notifying the office of the Dean at KYCOM. This agreement in no way obligates KYCOM to provide any specific number of students during any specific time period.

CONTRACTING PHYSICIAN

_____

NAME **(PLEASE PRINT)**

_____

(Signature)

Date _____/_____/_____

Social Security Number __ __ __/__ __ /__ __ __ __

KYCOM

_____

Joshua Crum, D.O.
Associate Dean for Clinical Sciences

Date _____/_____/_____

KYCOM ABBREVIATED CURRICULUM VITAE

(Please Print or Type)

NAME: _____

BUSINESS ADDRESS: _____

_____

BUSINESS TELEPHONE: _____

FAX: _____

EDUCATIONAL BACKGROUND:

UNDERGRADUATE: _____

_____

_____

_____

GRADUATE: _____

_____

MEDICAL: _____

_____

INTERNSHIP: _____

RESIDENCY: _____

BOARD CERTIFICATION (S): _____

_____

_____

ACADEMIC APPOINTMENTS: _____

_____

OTHER: _____