

# 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
- Background check from VeriCorp (No cost to you!)  
VeriCorp will send you an e-mail with instructions!



# University of Pikeville - Kentucky College of Osteopathic Medicine

## PHYSICIAN AFFILIATION AGREEMENT

This agreement with the University of Pikeville and its Kentucky College of Osteopathic Medicine (hereafter KYCOM), is solely intended to provide educational training opportunities for KYCOM students. With this affiliation, I agree to appointment as a KYCOM Adjunct Clinical Faculty or Guest Lecturer effective from the date signed below.

I understand it is anticipated I will participate in clinical teaching and/or guest lecturer opportunities in connection with this appointment. The rate or amount of compensation for teaching related to this Agreement will be set out in a written addendum to this Agreement, which is incorporated by reference into this Agreement and which KYCOM may update from time to time upon written notification.

I understand that with the acceptance of this Agreement, I will assist KYCOM in providing training for the osteopathic medical students on-campus and/or at off-campus affiliated clinical sites. I agree to follow the curriculum provided by KYCOM, and also agree to review, monitor, and provide feedback for revision of the curriculum as needed; however, in contrast to an employee of the University, I am not responsible for preparation of syllabi or oversight of any course, nor am I expected to participate in faculty meetings or committee responsibilities unless specifically invited by KYCOM Administration.

I acknowledge that for the purposes of this Agreement, I am an independent contractor, not a University or KYCOM employee, and therefore not entitled to benefits including, but not limited to, health insurance, workers' compensation, and unemployment insurance. As an independent contractor, I am eligible for compensation for services rendered consistent with addenda to this Agreement as referenced above, but agree and understand that I am solely responsible for my own taxes (including any tax consequences, penalties, and fees resulting from payment to me under this Agreement), and will be required to complete and update an IRS W-9 Form to receive financial compensation accordingly.

I also acknowledge I may be subject to additional terms and conditions while working with KYCOM students, if I am associated with or employed by a medical practice or facility with its own affiliation agreement with KYCOM, and agree to consult with my practice or facility, if applicable, concerning such terms and conditions.

When applicable, upon the completion of each student clinical rotation, I agree to complete the student's online E\*Value evaluation form within 30 calendar days of it being sent to me. In addition, I acknowledge and agree that I will not receive either payment or CME credit (if applicable) for the clinical rotation until the student evaluation is completed in the E\*Value system. I also understand that

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an evaluation of me, and my teaching, will be required from students whom I teach. Evaluations are one aspect of the continual faculty assessment process at KYCOM, and I should expect to receive feedback from this evaluation process. I further understand that I am encouraged to contact KYCOM at any time regarding current, past, or future students, curriculum, or with any questions or comments regarding grading or educational procedures.

My signature below affirms that I am duly licensed to practice medicine or osteopathic medicine in at least one jurisdiction and I will at all times maintain medical malpractice insurance of at least \$1,000,000/\$3,000,000 coverage. As a result of this Affiliation with the University and KYCOM, I agree to undergo a required University of Pikeville background check; abide by the University's policies on Sexual Misconduct, harassment and discrimination, and the Family Educational Rights and Privacy Act ("FERPA"); and will fully cooperate with University investigations and actions regarding allegations of non-conformity to these policies and laws. I agree to notify KYCOM immediately of any change in my practice status or professional credentials.

I agree to conduct any clinical teaching responsibilities under this Agreement consistent with KYCOM's manual and policies on clinical rotations, as may be amended from time to time and understand KYCOM will endeavor to provide me with updated copies of the same. I understand that KYCOM will provide me in advance with a list of the students I am being asked to precept in the clinical setting, and that I will be asked to approve the schedule of student clinical rotations. I may, at my discretion, make needed changes in my availability for teaching by contacting KYCOM in writing at least 20 business days prior to the change. I understand that I have the right to refuse any student(s) for lawful purposes by notifying the KYCOM Office of Clinical Affairs; however, once accepted, it is imperative that the Office of Clinical Affairs has early and prompt notice of any schedule or availability changes. This agreement in no way obligates KYCOM to provide any specific number of students during any specific period of time.

This agreement and Adjunct Clinical Faculty or Guest Lecturer appointment is for a term of three (3) academic years from the date of signature, but may be terminated, or not renewed, by either party without cause upon 90 calendar days written notice. I acknowledge this Agreement supersedes and replaces any prior Agreements, negotiations, and discussions between KYCOM and me concerning the subject matter addressed in this Agreement.

# University of Pikeville - Kentucky College of Osteopathic Medicine

Name \_\_\_\_\_ Specialty \_\_\_\_\_

Board Certified? Yes \_\_\_\_\_ No \_\_\_\_\_

Board Eligible? Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Office Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Number:

Office: \_\_\_\_\_ Home: \_\_\_\_\_

Fax: \_\_\_\_\_ Email Address: \_\_\_\_\_

If changes occur in my professional licensure and/or malpractice insurance during the duration of this academic appointment, the physician agrees to immediately notify and provide supporting documentation to KYCOM.

**Physician**

**For KYCOM**

\_\_\_\_\_  
Name (PLEASE PRINT)

Joshua R. Crum, DO  
Associate Dean for Clinical Affairs

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Signature)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# University of Pikeville- Kentucky College of Osteopathic Medicine

## PHYSICIAN AFFILIATION AGREEMENT ADDENDUM A

This Addendum is meant to only be applicable when part of a signed UPike- KYCOM Physician Affiliation Agreement, and has no standing when not used as an Addendum to said Agreement. All payment of moneys under this Agreement are not intended to compensate the undersigned as salary, but are solely meant to serve as a gratuity or "thank you" to the individual for providing education and training to KYCOM osteopathic medical students.

I acknowledge that for the purposes of this Agreement and Addendum, I am an independent contractor, not a University or KYCOM employee, and therefore not entitled to benefits including, but not limited to, health insurance, workers' compensation, and unemployment insurance. As an independent contractor, I furthermore agree and understand that I am solely responsible for my own taxes (including any tax consequences, penalties, and fees resulting from payment to me under this Agreement), and will be required to complete and update an IRS W-9 Form, and any other required documentation, to receive financial compensation accordingly. In addition, I reserve the right to forfeit payment at this, or anytime in the future, by not providing a fully completed IRS W-9 Form, or by providing written documentation of forfeiture to the KYCOM Dean's Office.

On a fiscal quarterly basis, KYCOM will distribute checks to each individual who has completed all paperwork, including student evaluations in E\*Value, and/or provided lectures to osteopathic medical students, including the submission of exam questions pertinent to the lectures, if applicable. KYCOM will pay \$500.00 for core and selective rotations. Payment for elective rotations is the responsibility of the student.

Payment for each **four-week Core or Selective Clinical Rotation** shall be:

\$500.00

and for each **Lecture** shall

be: \$ \_\_\_\_\_

**Pay to: \_\_\_ Physician \_\_\_ Affiliated Hospital (Refer to Physician Contract with hospital!)**

**Physician must indicate whether payment is to be paid directly to physician or to affiliated hospital!**

**\_\_\_ I elect to waive compensation!**

**PHYSICIAN**

\_\_\_\_\_  
**PHYSICIAN NAME (PLEASE PRINT)**

\_\_\_\_\_  
**ADDRESS**

\_\_\_\_\_  
**CITY/STATE/ZIP**

**For KYCOM**

**Joshua R. Crum, DO**

**Associate Dean for Clinical Affairs**

**KYCOM**

**147 Sycamore Street**

**Pikeville, KY 41501**

\_\_\_\_\_  
**(PHYSICIAN SIGNATURE)**

\_\_\_\_\_  
**SIGNATURE**

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## INFORMATION REGARDING BACKGROUND CHECK NEEDED FOR CREDENTIALING

You will receive an e-mail from VeriCorp like the one below.

**From:** [customerservice@vericorphr.com](mailto:customerservice@vericorphr.com) [<mailto:customerservice@vericorphr.com>]

**Sent:** Date

**To:** Physician Name

**Subject:** EXTERNAL: University of Pikeville is requesting an EZyApp Background Check.

**Importance:** High

Dear: Physician Name

As part of their background screening process, University of Pikeville performs a background check. Please click on the EZyApp Applicant Entry Link to provide data which will solely be used for the purpose of performing the background check.

Your user credentials are as follows:

UserID: UPike1

Password: UpikeEzy1!

Authorization Code: UPike

[Click For Instructions](#)

To Login: <https://www.ezycheck.net/VericorpEzyApp/>

Additional Instructions:

Thank You.

[FCRA Summary of Your Rights](#)

**EZyApp**<sup>TM</sup> / [Applicant Entry Link](#)

Notice of Confidentiality: This e-mail, including any attachments, is intended for the use of the individual or entity to which it is addressed and may contain confidential information that is legally privileged and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, you are notified that any review, use, disclosure, distribution or copying of this communication is strictly prohibited. If you received this communication in error, please contact the sender by reply e-mail and destroy all copies of the original message.

**If you have any questions regarding the credentialing process for KYCOM, please contact Angel Hamilton at [ahamilto@upike.edu](mailto:ahamilto@upike.edu). Thank you for your participation in our clinical program!**