WCUCOM ADJUNCT CLINICAL FACULTY AFFILIATION AGREEMENT



In order to start an academic file for you at William Carey University College of Osteopathic Medicine, please complete attached form and return it along with the following items:

- An updated copy of your CV (if you do not have an updated CV, an abbreviated CV form is attached for your convenience)
- □ A copy of your malpractice insurance facesheet.
- □ A copy of your current medical license.
- □ A copy of your W9 form to allow processing of your stipend.

Please return completed forms within 30 days to:

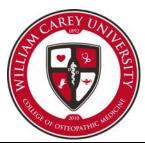
Makayla L. Merritt, PhD, MPH, ATC Director of Clinical Rotations 601-318-6087 (direct) 601-318-6452 (fax) mmerritt@wmcarev.edu

For Questions, please contact:

Rance McClain, DO, FACOFP, FAOASM Associate Dean of Clinical Sciences 601-318-6090 (direct) rmcclain@wmcarey.edu

<u>or</u>

Makayla L. Merritt, PhD, MPH, ATC Director of Clinical Rotations 601-318-6087 (direct) mmerritt@wmcarey.edu



WILLIAM CAREY UNIVERSITY COLLEGE OF OSTEOPATHIC MEDICINE

ADJUNCT CLINICAL FACULTY AFFILIATION AGREEMENT



FIRST NAME:	FIRST NAME: MIDDLE NAME:		L	LAST NAME:		SUFFIX:		
M.D	D.O		ОТН	OTHER:		DOB:		
PRACTICE SPECIALTY								
BOARD CERTIFIED: ☐ YES	□ NO ELIGIBI	LE: S	□NO		□ ABMS	ОТНЕ	R	
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PRIMARY OFFICE NAME AND								
ADDRESS:								
TELEPHONE	OPPICE /							
NUMBERS:	OFFICE: / / FAX: / /			OTHER:				
EMAIL ADDRESS:	TAA.	,						
EMAIL ADDRESS:								
HOSPITAL STAFF								
APPOINTMENT(S):								
Months you are not available to have students	JAN FEB M	IAR APR M	IAY JU	N JUL	AUG SEI	P OCT N	OV DEC	
How many students will	1 per year 2 per year 3 per year 4 per year 5 per year 6 per year 7 per year							
you be willing to take per year?	8 per year 9 per year 10 per year 11 per year 12 per year Other:							
Please choose one:	3 rd year stu	dents only	4th ye	ar student	ts only (no pa	ayment)	Both	
Office Use Only:	Hubsite:	□ Malpi	ractice	□ Medic	al License	□ CV	□ W 9	
	musite:	□ AMA	Profile	☐ Hospi Affiliation Agreem	on	□Evalue	☐ Scanned	

ADJUNCT CLINICAL FACULTY AFFILIATION AGREEMENT

This agreement with William Carey University College of Osteopathic Medicine (hereafter WCUCOM) 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 WCUCOM. 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 WCUCOM 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 WCUCOM, and that I am encouraged to contact WCUCOM 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 WCUCOM immediately of any changes to my practice status or should I decide to voluntarily terminate this agreement. This agreement may be terminated without cause at any time by WCUCOM. I understand that WCUCOM 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 WCUCOM in writing prior to the change. I may refuse any student / students by notifying the office of the Dean at WCUCOM. This agreement in no way obligates WCUCOM to provide any specific number of students during any specific time period.

NAME (PLEASE PRINT)	Rance McClain, DO, FACOFP, FAOASM Associate Dean for Clinical Sciences		
	Date:/		
Social Security Number OR Tax ID#	<u> </u>		
SIGNATURE	James M. Turner, DO, FACOFP, FACOEP		
Date://	Dean of WCUCOM Date: / /		

WCUCOM ABBREVIATED CURRICULUM VITAE (Please Print or Type)

	(Tituse Trini or Type)	
NAME:		
BUSINESS ADDRESS:		
BUSINESS TELEPHONE:		
FAX:		
EDUCATION:		
UNDERGRADUATE:		
GRADUATE:		
MEDICAL:		
INTERNSHIP:		
RESIDENCY:		
BOARD CERTIFICATION(S):	□AOA	□ ABMS
DATES:		
ACADEMIC APPOINTMENTS:		
DATES		
DATES:		
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OTHER:		