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 THE FOLLOWING ITEMS:

- ☐ **An updated copy of your CV (if you have this, if not, please fill out the optional, abbreviated CV attached-there is no need to complete this if you are sending a CV)**
- ☐ **A face copy of your malpractice insurance.**
- ☐ **A copy of your current medical license.**

Please return completed forms *within 30 days* to:

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

For Questions, please contact:

Beth A. Longenecker, DO, FACOEP, FACEP
Associate Dean of Clinical Sciences
(601) 318-6090 (direct)
blongenecker@wmcarey.edu

or

Makayla L. Merritt, Ed.S, 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:	MIDDLE NAME:	LAST NAME:	SUFFIX:
M.D.____ D.O. ____		OTHER: ____	DOB: _____

PRACTICE SPECIALTY:

BOARD CERTIFIED:	☐ YES	☐ NO		**ELIGIBLE:**	☐ YES	☐ NO	☐ AOA	☐ ABMS

PRIMARY OFFICE NAME AND ADDRESS:		
TELEPHONE NUMBERS:	**OFFICE:** / /	**OTHER:**
CELL:	**FAX:** / /	

EMAIL ADDRESS:

HOSPITAL STAFF APPOINTMENT(S):	

MS MEDICAL LICENSE:		**LICENSE #:**

Are there any months you don't want students? If so, please circle months you don't want students.	**JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC**
How many students will you be willing to take per year?	

WCUCOM ABBREVIATED CURRICULUM VITAE
(Please Print or Type)

NAME:		
BUSINESS ADDRESS:		
BUSINESS TELEPHONE:		
FAX:		
EDUCATION:		
UNDERGRADUATE:		
GRADUATE:		
MEDICAL:		
INTERNSHIP:		
RESIDENCY:		
BOARD CERTIFICATION(S):	**☐ AOA**	**☐ ABMS**
DATES:		
ACADEMIC APPOINTMENTS:		
DATES:		
OTHER:		

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. I agree to provide WCUCOM with at least a 90 day notice 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.

I authorize _____ to act on my behalf and release my personal information (copy of CV, face-copy of malpractice, and copy of MS medical license) to William Carey University College of Osteopathic Medicine.

CONTRACTING PHYSICIAN

NAME (PLEASE PRINT)

Social Security Number OR Tax ID#

SIGNATURE
Date: _____/_____/_____

WCUCOM

Beth A. Longenecker, DO, FACOEP, FACEP
Associate Dean for Clinical Sciences

Date: _____/_____/_____

James M. Turner, DO, FACOFP, FACOEP
Dean of WCUCOM
Date: _____/_____/_____