PHYSICIAN ASSISTANT PROGRAM
11300 NORTHEAST SECOND AVENUE
MIAMI SHORES, FL 33161-6695
Miami Shores (305) 899-3964 / fax (305) 899-4083
St. Petersburg (727) 302-6603 / fax (727) 302-6608
St. Croix (340)-692-5055 / fax (340)-692-5058
www.barry.edu/pa

ADJUNCT CLINICAL FACULTY APPLICATION

Please ***type*** or ***print*** clearly:

Full Name _____.
First **Middle** Last Title (MD, DO, PA-C, ARNP)

Office Telephone_____ Fax_____

Office Address_____
Street City State Zip

County: _____ E-mail_____

Please write N/A if not applicable

1. Has your license to practice medicine in any jurisdiction ever been suspended or revoked? ___Yes ___No
2. Have your hospital privileges ever been suspended, diminished revoked or not renewed? ___Yes ___No
3. Has your narcotic license ever been suspended? ___Yes ___No
4. Have you had any medical liability actions brought against you within the past 5 years? ___Yes ___No
5. Have any professional complaints been placed against you with the Florida Department of Health Medical Quality Assurance Licensing Board or any other state, national or territorial licensing entity? ___Yes ___No

Is the case ☐ **settled** ☐ **pending**

If you checked off yes to any of the above questions, please provide explanation and or documentation

As Adjunct Clinical Faculty at Barry University, I agree to abide by the by-laws of the Medical and Administrative Staff and by such rules and regulations as may be subsequently enacted. Moreover, by applying for an Adjunct Clinical Faculty appointment, I am giving written consent for Barry University to contact any organization or individual listed on this application or curriculum vitae. Further, I agree that I will not hold responsible Barry University or those contacted should my application be denied due to information received from said organization or individual. I fully understand that any false statement in or omission from this application constitutes cause for rejection and/or dismissal from the adjunct clinical faculty.

Adjunct Clinical Faculty are not employees of the University, but rather are volunteers willing to assist the University in the professional development of high quality health care providers, and shall be without entitlement to compensation or benefits for the appointed party.

_____ _____
Signature Date

Please Forward a Copy of the Following Items With Your Application:

- √ **State License/Registration**
- √ **DEA Number**
- √ **Curriculum Vitae or Résumé**
- √ **Evidence of Professional Liability Insurance**
- √ **Proof of board certification**

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CLINICAL SITE QUESTIONNAIRE

Board Certified in (circle ALL that apply):

☐ General Surgery ☐ Internal Medicine ☐ Family Medicine ☐ Psychiatry ☐ Pediatrics

☐ Obstetrics & Gynecology ☐ Emergency Medicine ☐ Other Board Certification _____

If you are a PA or NP, what specialty do you practice: _____

If you are a PA, NP please list the name(s) and license # of the MD/DO who will assume ultimate responsibility for the student being trained

_____

Practice Type: ☐ Solo Practice ☐ Group Practice ☐ Hospital Based Practice ☐ Other _____

Office Personnel: Office Manager _____ LPN_____ RN_____ CRNP _____ PA-C _____

MD/DO _____ Lab, X-Ray Tech _____ Other_____

Is there a medical library available for student use? Yes_____ No_____

List primary hospitals or outpatient centers where you are clinically active and the students will participate in patient care with you and how often you go to each.

1. _____
2. _____
3. _____
4. _____

Are students encouraged to accompany you on hospital rounds? Yes___ No___

Do you practice in the following settings (Please check ALL that apply):

☐ Outpatient Clinic ☐ Inpatient (Hospitalized Patients) ☐ Emergency Room ☐ Operating Room

☐ Long Term Care Setting (Nursing Home, Chronic Care, Inpatient Psychiatry, etc.)

Approximate hours per week ☐ 35 or less hrs./wk. ☐ 36-40 hrs./wk. ☐ 40+ hrs./wk.
If less than 35 hours, please explain – provide schedule

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Will the student(s):

See patients in nursing home or other long term care facility	Yes____ No____
Be on call with the preceptor?	Yes____ No____
Work weekends?	Yes____ No____
Perform procedures?	Yes____ No____
Assist in surgery?	Yes____ No____
Dictate medical records?	Yes____ No____
Does your facility have an office laboratory?	Yes____ No____
Do the students need to speak Spanish?	Yes____ No____
Does your facility have Electronic Medical Records?	Yes____ No____

Rural Underserved: ☐ Ambulatory Practice ☐ Community Health Center ☐ Correctional Facility
☐ Health Care Center/Homeless ☐ Health Professional Shortage ☐ Indian Health
☐ Inner City/Urban ☐ Migrant Health Center ☐ Rural Health Center
☐ Medically Underserved Population ☐ State/Local Health Dept. ☐ Nat Health Service

Will the students see (check all that apply):

☐ Infants ☐ Children ☐ Adolescents ☐ Adults ☐ Elderly

Students should report to:

Person _____ Title_____

Place _____

Time _____ Phone Contact_____ E-mail Contact _____

Correspondence to your office should be directed to:

Name/Title_____

Address_____

City_____State_____Zip_____

Phone_____ Fax _____

Email_____

Additional comments, concerns or information:

_____
_____
_____

Please direct any questions or concerns to the Physician Assistant Program Director of Clinical Education at:
Attn: Director of Clinical Education, Physician Assistant Program, Office 305-899-3964 Fax 305-899-4083