



## Application for Clinical Faculty Appointment (Profile of Practice)

Name:
Date of Birth: (required to verify credentials in the National Practitioner Database)
Email:

Primary Office Name:
Office Address:
Office Phone: _____ Office Fax: _____
Office Manager:
Office Manager Email:
List the hospital(s) and other facilities used by your practice (we need this information to ensure that we have appropriate Affiliation Agreements) <b><u>Name &amp; Location(s):</u></b>

Do you expect the students to (Please Circle):

Take after-hours call?	Yes	No
See patients in hospital?	Yes	No
See patients in emergency room?	Yes	No
Do obstetrical deliveries?	Yes	No

What percentage of your patients are non-English speaking? \_\_\_\_\_

Please list languages: \_\_\_\_\_  
\_\_\_\_\_

<b>Please attach the following three items:</b>
*Current CV      * Current State Medical License      *Current Medical Liability Policy

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_

**Please fax or email application to:**

**RVUCOM**

Office of Clinical Affairs

Fax: 720-875-2868

Email: oca@rockyvistauniversity.org