

**FAMILY MEDICINE RESIDENT'S RURAL ROTATION
Supervisor Application**

**Funded by the
Texas Higher Education Coordinating Board
Administered by the
Faculty Development Center**

Directions: Physicians seeking to serve as a Family Medicine Resident's Rural Rotation Supervisor are required to complete this application form. Please return completed application to:

Stacey Silverman, Program Director
Texas Higher Education Coordinating Board
Division of Academic Affairs and Research
P.O. Box 12788
Austin, Texas 78711-2788
(512) 427-6200

I. Supervisor Information

A. Physician Name (Please Print) _____

B. _____ ()
 (Office Address) Street City State Zip Code Phone

C. _____ ()
 (Home Address) Street City State Zip Code Phone

D. County of Practice Location _____ E. Date of Birth _____

F. Medical School and location _____

Year of Graduation _____

G. Please check the statement(s) which apply to you and provide the corresponding data.

I am: _____ Licensed to practice medicine in Texas.
 Texas Medical License Number _____

_____ Board-certified in Family Practice.
 Year of Next Recertification _____

_____ Residency-trained in Family Practice.
 If residency-trained, please provide name and location of residency program
 and date of graduation.

_____ Family Practice Residency Program Location Date of Completion

_____ Active member of the Texas Academy of Family Physicians. (Not Required)

H. I have previously served as a family practice preceptor in the Texas Statewide
 Preceptorship Program. _____ Yes _____ No

I. How long have you practiced in your community? _____ Years

J. Medical Malpractice Insurer _____

K. Do you plan to seek additional family physician associates in the near future?
 _____ Yes _____ No

II. Practice Characteristics

A. _____ Solo Practice _____ Partnership _____ Group Practice

1. If group practice, please indicate number of physicians in group. _____

2. Specialties represented in group: _____

B. Approximately what percent of your practice is:

1. _____% Surgical _____% Medical _____% Obstetrical _____% Pediatric _____% Industrial	2. _____% In-patient _____% Out-patient _____% Other (Please describe) _____ _____
--	---

3. _____% Private Self- Pay _____% Private 3rd Party Reimbursement _____% Medicaid _____% Medicare _____% Uninsured Indigent	4. _____% White _____% Black _____% Hispanic _____% Other	5. _____% Male _____% Female	6. Patient Age Profile _____% 0-10 yrs. _____% 11-25 yrs. _____% 26-55 yrs. _____% Over 55
---	---	------------------------------------	--

C. Which of the following are employed in your office?

_____ RN	_____ LVN	_____ Other	_____
_____ Physician Assistant	_____ Nurses Aide		_____
_____ Nurse Practitioner	_____ Lab Technician		_____
_____ Social Worker	_____ X-ray Technician		

D. Estimate the typical number of patients you have hospitalized at any one time: _____

E. Estimate the typical number of patients you see per day: _____

III. Community Characteristics

A. What is the approximate population of your community? _____

B. What is the approximate population of your practice "catchment area"? _____

C. 1. Is there a hospital in your community at which you have active admitting privileges? _____ Yes _____ No

2. If yes,

a. Hospital Name _____

b. Administrator _____

c. Address _____

d. Phone _____

e. Number of beds _____

3. If there is no hospital in your community, how far is it to the nearest hospital at which you have active admitting privileges?_____
- a. Hospital Name_____
 - b. Administrator_____
 - c. Address _____

 - d. Phone_____ e. Number of beds_____
4. Do you have active admitting privileges at any other hospital in the area?
____ Yes ____ No
- a. Would residents be using this hospital? ____ Yes ____ No
 - b. If yes, hospital name_____
 - c. Administrator_____
 - d. Address _____

 - e. Phone_____ f. Number of beds_____
5. Please briefly describe the community's recreational and cultural attractions:
- _____
- _____
- _____
- _____

IV. Physician

- A. Describe your involvement in community medicine (i.e., county health office, migrant workers' clinic, federally funded community health center, hospital utilization committees, etc.)
- _____
- _____
- _____

B. Are there any prerequisite courses or experiences that you feel are necessary for a resident doing a rotation with you? Yes No

C. If yes, please explain. _____

D. Can you provide housing for the resident? Yes No

E. If you cannot provide housing, is housing for the resident available in the community? Yes No

F. Can you provide meals for the resident? Yes No Some

G. If you cannot provide meals, are meals for the resident available in the community? Yes No Some

H. The Rural Rotation will last for one month. Are there any times of the year when you definitely do **not** want to have a resident assigned to you? Yes No

If yes, specify those periods below.

FROM	TO
Month/Day	Month/Day
_____	_____
_____	_____
_____	_____

I. Please list any other attributes you feel would help residents in selecting your practice as a rural rotation site.

