Texas Higher Education Coordinating Board

Family Medicine Rural Rotation
Supervisor Application

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 by email to:

Ernest Jacquez, Program Director
Texas Higher Education Coordinating Board
Attn: Family Practice Rural Rotation
1200 East Anderson Lane
Austin, Texas 78752
(512) 427-6200
familypractice@highered.texas.gov

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. _____
(Email Address)

E. County of Practice Location_____ F. Date of Birth_____

G. Medical School and location _____

Year of Graduation_____

H. 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)

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

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

K. Medical Malpractice Insurer_____

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

3.	4.	5.	6. Patient Age Profile
_____% Private Self- Pay _____% Private 3rd Party Reimbursement _____% Medicaid _____% Medicare _____% Uninsured Indigent	_____% White _____% Black _____% Hispanic _____% Other	_____% Male _____% Female	_____% 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. Do you have active admitting privileges at a local hospital?
_____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 Month/Day	TO Month/Day

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