MIDWESTERN UNIVERSITY

EYE INSTITUTE
CHICAGO COLLEGE OF OPTOMETRY
3450 Lacey Road
Downers Grove, IL 60515
Phone: 630/743-4500

To be completed by site:

Site Name: ______________________

Primary Clinic Address: ______________________

Site Phone: ______________________

Site Fax: ______________________

Site Website: ______________________

Primary Contact/Site Coordinator: ______________________

Contact Phone Number: ______________________

Contact Email: ______________________

	Do you have a room or space designated for the following:	**Yes**	**No**
Physical Facilities Information	Contact Lens Training		
	Dispensary		
	* Exam Lanes (how many)		
	Medical Laboratory		
	Ophthalmic Laboratory		
	Pre-testing		
	Specialty Testing (specify)		
	Vision Therapy		

	Do you have the following equipment:	**Yes**	**No**
Equipment Information	* Auto-perimeter		
	Auto-refractor		
	Contact Lens Modifying Equipment		
	Corneal Topography		
	Keratometer		
	Laser (specify)		
	Lensometer(Auto Manual)		
	Low Vision Devices		
	* Optic Nerve Analyzer/OCT (specify)		
	Pachymeter		

Equipment Information (continued)	Do you have the following equipment:	Yes	No
	Photography, Anterior		
	* Photography, Posterior		
	Ultrasonography		
	Electrophysiology, VEP, ERG, EOG		
	Tear Osmolarity or other objective ocular surfaces disorder		
	Radiuscope		
	* Slit Lamp or Biomicroscope		
	Sphygmomanometer		
	Tonometer for: ☐ Goldmann ☐ Non-Contact Tonometer ☐ Other (specify)		
	Other (specify)		

Diagnostic Procedures Performed	Do you perform these procedures?	Yes	No
	Angiography ☐ Fluorescein ☐ Indocyanine Green		
	Binocular Vision/Accommodation Testing		
	Biomicroscopy		
	Contrast Sensitivity Testing		
	* Corneal Topography		
	Cytology		
	Electrophysiology		
	Exophthalmometry		
	Gonioscopy		
	Laser Procedures (specify)		
	Medical Laboratory Testing		
	Refractions		
	Neurological Testing ☐ Pupil Testing ☐ Cranial Nerve Screening		
	Ophthalmoscopy ☐ Direct ☐ 78D/90D/Superfield/Other ☐ Binocular Indirect		

Diagnostic Procedures Performed (continued)	
	Perimetry ☐ Standard Automated ☐ Perimetry SWAP ☐ Frequency Doubling
	Photography ☐ Anterior Segment ☐ Posterior Segment
	Specialized Testing (specify)
	Tonometry ☐ Goldmann ☐ Non-Contact ☐ Other (specify)
	* Ultrasound ☐ A Scan ☐ B Scan ☐ Other (specify)

Treatment and Management	**Do you treat, prescribe for, or manage, either independently or co-manage:**	**Yes**	**No**
	Amblyopia		
	Anterior Segment Disease		
	Age Related Macular Degeneration		
	Binocular Vision Problems		
	Chalazion Injection/Excision		
	Computer Vision Syndrome		
	Contact Lenses		
	Orthokeratology		
	Dry Eye Syndrome		
	Foreign Body Removal		
	Glaucoma		
	Hospital Emergencies (on call)		
	Injectables (specify)		
	Keratoconus		
	Low Vision Rehabilitation		
	Ocular Trauma		
	Pediatrics		
	Pre/Post Surgical Management ☐ Cataracts ☐ Glaucoma ☐ Refractive Surgery ☐ Retina ☐ Other (specify)		

Treatment and Management (continued)			
	Ocular Prosthetic Services		
	Punctal Dilation and Irrigation		
	Punctal Plugs		
	Sports Vision		
	Strabismus		
	Stromal Puncture		
	Suture Removal		
	Vision Development		
	Vision Therapy		
	Any other advanced therapy not listed		

Practice Information			
	Type of practice (solo, multidisciplinary, federal service, etc.)		
	Length of time at this location?		
		YES	**NO**
	Are you the owner, co-owner, part-owner, employee or other?		
	Are you certified for diagnostic pharmaceuticals?		
	Are you certified for therapeutic pharmaceuticals?		
	Are you certified for injectables?		
	* What are your office hours? Monday Tuesday Wednesday Thursday Friday Saturday Sunday		
	How many of the following personnel are in your office? Optometrists Ophthalmologists Technicians Office Staff Others (specify)		
	What are the estimated numbers or percentages of the following appointments? % Patients seen by appointment % No Shows # Schedule waiting time # Comprehensive exams/day # Patient visits per day # Minutes of complete/final exam		
	What are the estimated percentages by payment type? % Private Pay % Other Insurance Plans (specify) % Medicare % Medicaid		
	What are the estimated percentages of patients seen in the following types? % Ocular Disease % General Practice % Contact Lenses %Pediatrics % Vision Therapy/Development % Low Vision % Ophthalmic Dispensing % Sports Vision %Pre/Post Surgical Management		
	What are the estimated percentages of out-of-office care? % Hospital % Nursing Home % Prison Care % Home Care % School Screenings % Other (specify)		

Preceptor Responsibilities	What topics do you expect to cover with the student during the orientation process?	
	How will you introduce your student to your new and existing patients?	
	What expectations do you have about the amount of instruction time your student will require?	
	* The basis of the Optometric Externship program depends on independent skills applications, as well as clinical decision making. Observation should general be reserved for clinical procedures that are not within the scope of Optometry (observing complex surgical procedures by an ophthalmologist for example). Are you comfortable with the idea of permitting the student to independently examine patients after you have observed him/her for a period of time?	**Yes** **No**
	Guidance and mentoring from the Preceptor are wanted and expected by the students. What strategies or educational approaches will you employ?	
	Have you taught before and if so, when and where?	
	Teaching requires familiarity with current literature. Are you willing to stay abreast of scientific findings and require your student to research subjects that he/she shows a weakness in?	**Yes** **No**
	Are you active in any local, state or national civic or optometric organizations? **Yes** **No**	If so, will you invite your student to attend functions with you? **Yes** **No**
	If you have a private practice, will you allow the student to spend time with your billing, insurance and coding employees so the student may gain a better understanding of how a private practice is run?	**Yes** **No** **N/a**
	Will the student have access to the internet while at your clinic?	**Yes** **No**
	Will you arrange for the student to observe other practice settings which complement or augment your practice?	**Yes** **No**

<table>
<tr><td rowspan="13">Preceptor Responsibilities (continued)</td><td colspan="2">Do you currently host students from other optometry schools? Yes No
If yes, which programs?

If no, have you ever hosted in the past? Which programs?</td></tr>
<tr><td>The CCO student demographics vary by class and the college cannot guarantee that you will have a student every year, much less every quarter. Will this schedule be acceptable at your practice?</td><td>Yes No</td></tr>
<tr><td>Is housing offered at your site? If so, what quarters are available?</td><td>Yes No</td></tr>
<tr><td>Is travel between multiple sites expected?</td><td>Yes No</td></tr>
<tr><td colspan="2">* How many patient encounters do you anticipate providing an individual student over the 12 week rotation? An encounter refers to direct patient care and involvement in clinical decision making.
☐ 0-250 ☐ 251-400 ☐ 401-650 ☐ 651-800</td></tr>
<tr><td>Do you work with other types of health providers (other than optometry) in your clinic?</td><td>Yes No</td></tr>
<tr><td colspan="2">* Number of CCO students your externship site can host per quarter
Summer: Winter:
Fall: Spring:</td></tr>
<tr><td colspan="2">* Please list all licensed clinicians who will be directly supervising externs during their rotation
<table>
<tr><th>Name of Clinician</th><th>Number of Years in Practice</th><th>ACOE Residency Trained</th></tr>
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<tr><td>* Does your site have a process to grant privileges to clinicians? (If yes, please provide a copy)</td><td>Yes No</td></tr>
<tr><td>* Have any of the above licensed clinicians that will be precepting CCO student clinicians had any adverse actions against their professional license? If yes, please explain action, dates, and resolution? (use separate sheet)</td><td>Yes No</td></tr>
<tr><td>* Does your site use AOA Optometric Clinical Practice Guidelines or AAO Preferred Practice Pattern Guidelines, when applicable?</td><td>Yes No</td></tr>
</table>

* Items may be required for final review

Clinic Description (Please fill out this section to tell us more about your site, location, and special features, or any other information that you believe is important to share about your clinic):

Please return this completed form along with the following documents for each doctor who will be instructing students:

- ☐ Copy of Optometry License
- ☐ Proof of Insurance
- ☐ Curriculum Vitae
- ☐ Clinical Privileging Document (if applicable)

External Rotation Site Survey can be returned US Mail, email, or fax to:

Shannen Hamlin
Clinical Education Coordinator
Midwestern University
Chicago College of Optometry
3450 Lacey Road
Downers Grove, IL 60515
P 630-743-4812
F 630-743-4835
Optometry_Rotations@midwestern.edu