DES MOINES UNIVERSITY
COLLEGE OF PODIATRIC MEDICINE AND SURGERY
3200 Grand Avenue, Des Moines, Iowa 50312
515-271-1489

Clinical Faculty Teaching Agreement

Name: _____ ☐ DPM APMA#_____
(PLEASE PRINT) ☐ MD AMA# _____
☐ DO AOA# _____
☐ Other _____

Practice Specialty: _____

Board Certified: ☐ Yes ☐ No Board Eligible: ☐ Yes ☐ No

Primary Office Address: _____

_____

_____

Telephone Numbers: Office: _____/_____/_____ Home: _____/_____/_____

Fax: _____/_____/_____ E-Mail: _____/_____/_____

State License #: State: _____License #: _____Exp Date:_____

State: _____License #: _____Exp Date:_____

Current Medical Malpractice Insurance Carrier: _____

Certificate #: _____ Limits: _____/_____

Affiliated Hospital: _____

Address: _____

_____

PLEASE RETURN THE COMPLETED TEACHING AGREEMENT ALONG WITH A COPY OF YOUR MEDICAL LICENSE, BOARD CERTIFICATION, IF APPLICABLE, AND A CURRENT CURRICULUM VITAE. If you do not have a curriculum vitae available, you may complete the attached CPMS Abbreviated Curriculum Vitae. *SPECIAL NOTE*: Using the abbreviated curriculum vitae may not provide enough information to assign appropriate rank.

FOR OFFICE USE ONLY:

APPLICATION ACCEPTED: ☐ *YES* ☐ *NO* *RENEWAL ACCEPTED:* ☐ *YES* ☐ *NO*

ADJUNCT FACULTY RANK: _____ *DATE:* ___/___/___

FACULTY TEACHING AGREEMENT

This agreement with the College of Podiatric Medicine and Surgery, Des Moines University (hereafter CPMS/DMU) is to provide clinical training opportunities for the students, especially in the fourth year. With this teaching agreement, I seek appointment to the adjunct clinical faculty of CPMS/DMU. I understand that with the acceptance of the agreement, I will assist in providing clinical training for the podiatric medical students. In addition, I agree to follow the curriculum provided by the clinical affairs department at CPMS/DMU. I will also agree to review, monitor and provide comments for the revision of the curriculum as needed.

Upon the completion of each individual training period I will, within 30 days, fully complete and return to CPMS/DMU a student evaluation form. I also understand that an evaluation of me will be required from each student who rotates with me. I understand that this is one part of the continual faculty evaluation process at CPMS/DMU, and that I am encouraged to contact CPMS/DMU regarding current, past, or future students, curriculum, or questions and comments regarding grading or training procedures.

With this agreement, I affirm that I am duly licensed to practice medicine, have in effect current medical malpractice insurance, and have appropriate privileges to practice my specialty at an area hospital. I will give immediate written notification to CPMS/DMU of any changes in my practice status. I agree to provide CPMS/DMU with at least 90 days written notice should I decide to voluntarily end this agreement. This agreement may be terminated without cause at any time by CPMS/DMU. I understand that CPMS/DMU will provide me in advance with a list of any changes in the approved schedule. I may, at my discretion, make needed changes in my availability for teaching by contacting CPMS/DMU in writing prior to the change. I may refuse any student(s) by notifying the office of the dean of CPMS/DMU. This agreement in no way obligates CPMS/DMU to provide any specific number of students during any given time period.

CONTACTING PHYSICIAN	CPMS/DMU
_____	_____
(Please Print Name)	Kevin Smith, DPM, MS Associate Dean for Clinical Affairs/CPMS Des Moines University
_____	
(Signature)	
DATE: _____/_____/_____	DATE: _____/_____/_____

CPMS/DMU ABBREVIATED CURRICULUM VITAE

(PLEASE PRINT OR TYPE WHEN FILLING OUT THIS FORM)

NAME: _____

BUSINESS ADDRESS: _____

_____

_____

BUSINESS PHONE #: _____/_____/_____ FAX #: _____/_____/_____

☐ APMA#,☐ AOA#, or ☐ AMA# _____

EDUCATIONAL BACKGROUND:

UNDERGRADUATE SCHOOL:	*GRADUATE SCHOOL:*
MEDICAL SCHOOL:	*INTERNSHIP:*
RESIDENCY:	*BOARD CERTIFICATION(S):*
ACADEMIC APPOINTMENTS:	*OTHER:*

HOSPITAL STAFF APPOINTMENTS: _____

_____

_____