



Postgraduate Physician Assistant Program  
PO Box 2037  
Philippi, WV 26416

Telephone: (304) 457-6356  
Fax: (304) 457-6308  
E-Mail: childerswa@mail.ab.edu

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**CLINICAL SITE APPROVAL  
HOSPITALIST PROGRAM – MASTER'S OPTION  
Postgraduate Physician Assistant Program**

**TO THE STUDENT:**

Students entering the Hospital Medicine Track are required to secure and maintain full-time employment as a physician assistant in an approved clinical setting. Selecting an appropriate clinical site, which will meet program and student objectives, is very important. Students currently employed may be able to complete program requirements at their current site. The *Clinical Site Approval* form must be approved prior to enrollment of each year.

**REQUEST TO CHANGE CINICAL SITES (Current Students Only):**

Changing your clinical site during completion of the Program is discouraged but may be approved if the student can provide reasonable documentation that changing clinical sites will improve their educational program. Changing clinical sites simply for financial gain will not be approved. Written approval from the Program Director and Medical Director is required to seek approval of a clinical site change. Please be advised that approval is required prior to resignation from an approved site. Students that resign from their approved site without first seeking approval, or if their employment is terminated for any reason, risk the possibility of being suspended or dismissed from the Postgraduate Physician Assistant Program and/or extending the time required to complete program requirements.

**APPROVAL PROCESS:**

Please arrange a meeting with the Medical Director at your employing clinical site to discuss your plans for entering the Hospitalist Track Postgraduate Physician Assistant Program. At this meeting you should discuss your clinical objectives and employment expectations as related to the Program and the benefits your advanced education will provide to the employing site. It is important for your Medical Director to understand the Program's clinical and didactic components and to approve of your entering the Program.

The information and documentation that you and your Director provide on this form will assist in determining whether or not your clinical site is approved. It is important that you and your Director agree that an adequate learning environment, including educational and clinical support, exists at the proposed site. The clinical site must also provide and agree to the following:

- A. The supervising physician and/or department staff is willing to provide an adequate learning environment, including academic and clinical support as needed.
- B. Physicians and staff must support the advanced role of physician assistants with specialty training in hospital medicine.
- C. Willingness on the part of the precepting physician(s) to provide clinical experiences, including work-up of higher acuity patients under supervision as appropriate.
- D. Guaranteed release time to complete didactic requirements.

Students seeking clinical site approval are responsible for returning this form to the Postgraduate Physician Assistant Program after all information has been completed. Forms should be returned to William A. Childers, Jr., MS, PA-C, Program Director, Postgraduate Physician Assistant Program, Alderson-Broaddus College, 500 College Hill Drive, PO Box 2037, Philippi, WV 26416. Telephone: (304) 457-6356; Fax: (304) 457-6308; E-Mail: childerswa@mail.ab.edu. A copy of this form will be returned to the student indicating approval status.

**STUDENT INFORMATION:**

Student's Name: \_\_\_\_\_ S.S. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Cell Number: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Work Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**PROPOSED CLINICAL SITE:**

Name of Clinical Site: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

If you are not already employed at this site, what is the projected first day of employment? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Supervising Physician: \_\_\_\_\_

Address: (If different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Fax: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

E-Mail Address (if applicable): \_\_\_\_\_

**CLINICAL SITE DATA:**

1. The clinical site is located in which of the following populations:

\_\_\_\_\_ Under 10,000    \_\_\_\_\_ Under 25,000    \_\_\_\_\_ Under 50,000    \_\_\_\_\_ Over 50,000

2. Type of clinical setting:

\_\_\_\_\_ Office Based    \_\_\_\_\_ Hospital Based    \_\_\_\_\_ Both    \_\_\_\_\_ Neither (if neither, please explain)

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3. Is the site located in an underserved area?    \_\_\_\_\_ Yes    \_\_\_\_\_ No

4. What is the approximate number of patients served?    \_\_\_\_\_

5. How many physicians are in the group?    \_\_\_\_\_

6. How many physician assistants are in the group?    \_\_\_\_\_

7. If the site is hospital based, what is the number of inpatient medical adult beds?    \_\_\_\_\_

8. If the site is hospital based, what is the number of adult ICU/CCU/Critical Care beds?    \_\_\_\_\_

9. Briefly describe the clinical environment of your employment and the type of patients you will be serving:

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10. How do you foresee this Program assisting you with your current job position, or with future positions?

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**GENERAL PROGRAM INFORMATION:**

The student and clinical site are advised of the following on-site requirements and other general information as follows:

**1. Role of the Supervising Physician:**

The supervising physician must support the concept of advanced education and specialty education in hospital medicine for physician assistants. The student’s work schedule must provide opportunity for exposure to a variety of patient types normally served in a typical family practice and/or hospital medicine setting and as appropriate in keeping with the student’s education and abilities. Supervising physicians must be willing to assist in the student’s learning process by answering student questions and providing opportunities for learning through a variety of clinical experiences. Supervising physicians are not required to provide on-site instruction such as lectures or other time-consuming teaching tasks. Supervising physician may be asked to evaluate the student each semester by completing a standard program evaluation.

**2. On-site Requirements at Alderson-Broaddus College:**

<b><u>First Year</u></b>	<b>Fall Semester:</b>	One weekend per month (September – December)
	<b>Spring Semester:</b>	One weekend per month (January-April)
<b><u>Second Year</u></b>	<b>Fall Semester:</b>	One weekend per month (September – December)
	<b>Spring Semester:</b>	One weekend per month (January – April)

**NOTE:** A weekend consists of Friday through Sunday. Class schedules vary slightly each semester. The College reserves the right to alter on-campus class schedules as needed and appropriate to satisfy program objectives.

**3. Tuition Payment:**

Tuition is the responsibility of the student and may be paid by the student or the clinical site according to the following schedule:

- \$ 6,520 by September 2006
- \$ 6,520 by January 2007
- \$ 3,402 by September 2007
- \$ 5,103 by January 2008

**NOTE:** Tuition is subject to change effective July 1 of each year, pending action of the Board of Trustees for Alderson-Broaddus College.

**STUDENT CERTIFICATION:**

I hereby certify that I have discussed the Postgraduate Physician Assistant Program with my supervising physician and/or Medical Director at the site designated on this form and have been granted permission and/or support to enter the Program. I feel this clinical site can provide the clinical experiences and support to meet my personal career objectives and program requirements. I agree to arrange payment of the required tuition and other expenses associated with the Program. I understand that it is my responsibility to arrange for malpractice insurance through my employer or to purchase coverage. I understand that Alderson-Broaddus College does not provide malpractice insurance as a result of the program’s employment requirements. I certify that all information provided on this form is accurate and complete. I certify that I may be dismissed or suspended from the Program for falsifying information.

**STUDENT’S NAME:** \_\_\_\_\_ (Please type or print legibly)

**STUDENT’S SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SUPERVISING PHYSICIAN CERTIFICATION:**

I hereby certify that the information on this form is accurate and complete to the best of my knowledge. I certify that I have discussed the Postgraduate Physician Assistant Program with the student and approve of the student's enrollment in the Hospital Track. I certify that our clinical site is willing to provide clinical experience with a variety of patients and meet all requirements stipulated in **Section 2** of this document. I certify that the above-mentioned physician assistant's projected first day of employment to be: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

**SUPERVISING PHYSICIAN:** \_\_\_\_\_ (Please type or print legibly)

**SUPERVISING PHYSICIAN'S SIGNATURE** \_\_\_\_\_

**DATE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**PROGRAM APPROVAL ( For official use only)**

The Program reserves the right to require a site visit prior to final approval.

**APPROVAL STATUS:**      \_\_\_\_\_ Approved      \_\_\_\_\_ Not Approved

**Medical Director's Signature:** \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Program Director's Signature:** \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_