# Clinical Faculty Application Cover

*Please ensure the document is completed in its entirety and that it accompanies all applications submitted to VCOM. Incomplete information will delay the faculty appointment process.*

☐ Initial Appointment Application OR ☐ Re-Credentialing/Re-Activation Application

**Application Checklist:**

*VCOM can accept online verification of State License and Board Certification ONLY.*

**Checklist for Initial Appointment**

- ☐ Current Curriculum Vitae
- ☐ Proof of State Medical License
- ☐ Proof of Board Certification
- ☐ Proof of Residency Certificate
- ☐ Proof of Medical School Diploma

**Checklist for Re-Credentialing/Re-Activation**

- ☐ Current Curriculum Vitae
- ☐ Proof of State Medical License
- ☐ Proof of Board Certification

**Preceptor Information (completion of all fields is required unless optional is indicated):**

| | |
|---|---|
| Preceptor Name (Last, First, Middle Initial): | |
| Degree (If DO, need AOA #): | AOA # |
| Phone Number: | |
| Email Address: | |
| Gender (optional): | |
| Race (optional): | |
| Primary Board Certification: | |
| Secondary Certification: | |
| Department / Discipline: | |
| Rank Requested: | |
| Primary Practice Name (Location of VCOM Rotations):<br>Street Address<br>City, State, Zip | |
| Practice Office Manager Name: | |
| Email/Phone: | |
| Core Site Name: | |
| Hospital Affiliation(s): | |
| Number of students the preceptor will take per rotation: | |

**Preceptor Payment** (check the one that applies & include attachment if required)**:**

**Payment**

- ☐ Payment Directly to Preceptor (W-9 Attachment Required)
- ☐ Payment to Practice Office (W-9 Attachment Required)
- ☐ Payment to Hospital

Submitted by (name of site coordinator, program director, etc.):

**Please forward documents to:**

**Christine** Ezell

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