WCVM PRIMARY CARE CLINIC EXPRESSION OF INTEREST FORM

1. Clinic Information

Clinic Name: **Email Address:**

Clinic Address: **Phone Number:**

City/Province:

Website (if applicable):

2. Primary Supervisor

Full Name *(including middle)*:

DVM College & Year of Graduation: **Phone Number:**

Home Mailing Address:

Board Certification (if any): **Email Address:**

3. Additional Clinicians

Full Name *(including middle)*	**Phone Number**	**Home Mailing Address**	**DVM College**	**Year of Graduation**	**Board Certification (if any)**

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4. Species Case Load Distribution

Please estimate the percentage of each species seen at your clinic:

Bovine: ___% Equine: ___% Feline: ___% Canine: ___% Other (please specify): ___%

5. Primary Care Certification

Please review and certify the following:

> *Primary care refers to initial and ongoing care of domestic species by a veterinarian. These practices should focus on emergent and/or common conditions, general surgical procedures, preventative medicine and general case management. The primary case load, as seen by students, shall not include more than 10% referral cases under supervision of a board-certified veterinarian. Discipline-specific specialty clinician supervision will not be allowed. The practice shall not be an emergency-only center.*

☐ I certify that this clinic meets the definition of a primary care practice as outlined above.

6. Clinical Training Commitment

☐ I certify that the clinic will provide a **minimum** of 40 hours per week of clinical training for the student and will adhere to the WCVM Clinical Hours Guidelines. Expected hours per week: _____

☐ I certify that the student will not receive financial compensation while under supervision of this externship.

7. Isolation Facility

☐ We have an isolation facility on-site

☐ We do not have an isolation facility. If no facility, please **attach** your isolation procedures or **describe** below:

_____

_____

_____

_____

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8. Housing

☐ Housing is provided for students ☐ Housing is not provided

Cost: $_____

9. WCVM Training Certification

☐ I certify that all supervising clinicians will complete the WCVM-provided training prior to hosting a student.

_____

Primary Supervisor Signature

_____

Date

Submit completed form to wcvm.curriculum@usask.ca