ILLINOIS COLLEGE OF OPTOMETRY

Externship Program Application

3241 South Michigan Avenue - Chicago, Illinois 60616 - www.ico.edu

Date of Submission: _____ /_____ /_____

Name of Clinic: _____

Name of Student referring this site (if applicable): _____

Brief Description of Clinic:

Number of Exam Lanes: _____

Optical Dispensary: ☐ Yes ☐ No

CL Training Room(s): ☐ Yes ☐ No

Pretesting Room(s): ☐ Yes ☐ No

Vision Therapy Room(s): ☐ Yes ☐ No

Specialty Testing Room(s): ☐ Yes ☐ No

Laser Room(s): ☐ Yes ☐ No

Facility Location

Located in the US? ☐ Yes ☐ No

Street Address: _____

City: _____ **State / Province:** _____

Zip: _____ **Country:** _____

Region (If in the US):

☐ Western US ☐ Northwest US ☐ Northeast US ☐ Southwest US ☐ Midwest US ☐ Southeast US

☐ Alaska ☐ Hawaii ☐ Puerto Rico

Facility Basics

Type (choose one):

☐ Veteran Affairs

☐ Private

☐ Commercial

☐ IHS/Community Health

☐ Hospital

☐ Military

Category (choose one):

☐ Veteran Affairs

☐ Primary Care / Basic Contact Lens

☐ Peds / Vision Rehab / Oc Disease / Specialty Contact Lens

Specialty (check all that apply):

☐ Primary Care

☐ Contact Lens

☐ Pediatrics / Vision Therapy

☐ Vision Rehab

☐ Ocular Disease

Contact Liaison Full Name: _____

Contact Email Address: _____

Contact Phone: _____

Facility Website URL: _____

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Facility Details

Do you accept ICO students every quarter?
☐ Yes ☐ No

If No, which quarter do you accept:
☐ Summer ☐ Fall ☐ Winter ☐ Spring

Number of ICO students accepted each quarter:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Do you provide formal journal club / case discussion / grand rounds?
☐ Yes ☐ No

Is there a residency program?
☐ Yes ☐ No

Other externship affiliations?
☐ Yes ☐ No

*If Yes, which school(s):*_____

Are meals provided?
☐ Yes ☐ No

Is an automobile necessary?
☐ Yes ☐ No

Is there onsite parking?
☐ Yes ☐ No

Does your practice follow AOA Clinical Practice Guidelines?
☐ Yes ☐ No

If in private practice, will the student be educated in billing and coding during their rotation?
☐ Yes ☐ No

Is there an orientation period/process?
☐ Yes ☐ No

If Yes, please describe:

Does your site provide any type of interprofessional education (IPE) or collaborative practice (team based)?
☐ Yes ☐ No

If Yes, what specialty(s):

If Yes, does it involve:
☐ *Students* ☐ *Practitioners* ☐ *Both*

Please describe:

Equipment Students Are Required to Bring:

Is there housing availability or a stipend?
☐ Yes ☐ No

If Yes, please describe:

Will the student be primarily examining patients independently?
☐ Yes ☐ No

If Yes, please describe typical daily schedule:

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Attending Staff - Full Time

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Attending Staff - Part Time

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Full Name and Degree: ______________________

Areas of Specialty (check all that apply):

☐ Primary Care ☐ Contact Lens ☐ Pediatrics / Vision Therapy ☐ Vision Rehab ☐ Ocular Disease

Student Clinic Hours

Are the student hours the same Monday - Friday? ☐ Yes ☐ No

Mon Start Time: _____ **Mon** End Time: _____

Tues Start Time: _____ **Tues** End Time: _____

Wed Start Time: _____ **Wed** End Time: _____

Thur Start Time: _____ **Thur** End Time: _____

Fri Start Time: _____ **Fri** End Time: _____

Sat Start Time: _____ **Sat** End Time: _____

Sun Start Time: _____ **Sun** End Time: _____

Additional Info About Hours: _____

Number of Student Encounters

Average number of patients per week per student?

_____

How many involve special testing?

_____

How many are observation only?

_____

Relative Percent of Student Encounters

Routine Refractive %

_____

Ocular Disease %

_____

Contact Lens %

_____

Pediatric / Binocular Vision / Vision Therapy %

_____

Low Vision %

_____

Miscellaneous Comments:

Please provide 3 learning objectives for students at your practice:

Please email this completed form along with CV's, licenses, and proof of insurance to externship@ico.edu or fax it to (312) 949-7749. Thank you.

SUBMIT FORM

Please contact Dr. Elyse Chaglasian, Assistant Dean for Community Based Education, with any questions at echaglas@ico.edu or (312) 949-7122.