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):

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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, diplomas, residency/fellowship certificates (if applicable) and proof of insurance to externship@ico.edu. Thank you.

SUBMIT FORM

Please contact Dr. Jaymeni Patel, Assistant Dean for Community Based Education, with any questions at jpatel@ico.edu.