

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):			
Date of Birth:		Phone Number:	
DVM College:			
Year of Graduation:		Email Address:	
Home Mailing Address:			
Board Certification (if any):			

3. Additional Clinicians

Full Name (including middle)	DVM College	Year of Graduation	Board Certification (if any)

4. Species Case Load Distribution

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

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

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5. Student

Have you discussed this rotation with a student? ☐ Yes ☐ No

Student Name (if yes):

6. 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 outline above.

Initials

7. 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.

Initials

8. Isolation Facility

We have an isolation facility on-site ☐ Yes

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

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9. Housing

Housing is provided for students ☐

Housing is not provided ☐

Cost: \$

10. WCVM Training Certification

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

Initials

Primary Supervisor Signature

Date

Submit completed form to wcvm.curriculum@usask.ca