PRECEPTORSHIP
PRACTICE ASSESSMENT QUESTIONNAIRE

Completion of this form by the PRACTICE for approval by the Louisiana Board of Veterinary Medicine is required AT LEAST TWO WEEKS PRIOR to the start of the preceptorship. Limited approval for a specialty facility, such as but not limited to, referral clinics, research facilities, and humane societies, may take longer as the request must go before the full Board at its bi-monthly meeting.

INDICATE: ☐ New ☐ Update

Office Use ONLY
☐ Full Approval
☐ Limited Approval

Please PRINT or TYPE all information

PRACTICE NAME

ADDRESS OF PRIMARY LOCATION:	TELEPHONE ( )
	Will preceptee work at this address? ☐Yes ☐No
ADDRESS OF SATELLITE LOCATION:	TELEPHONE ( )
	Will preceptee work at this address? ☐Yes ☐No

1. Does practice carry liability insurance to cover preceptees during the period of the preceptorship (DVM applicant)?
   ☐Yes ☐No
   PLEASE NOTE: Students are not covered by the Louisiana Board of Veterinary Medicine or the LSU School of Veterinary Medicine. The Board strongly recommends that the employing practice carry coverage on all preceptees. Inexpensive coverage may be available with a rider to your AVMA liability policy.

2. Is this application being made at the request of a preceptee (DVM applicant)? ☐Yes ☐No
   If yes, please list name of preceptee who requested that you apply to the program:
   _____
   You will be notified of your status after review by the Board. Approvals are valid for a period not to exceed two years. If approved, do you want to receive an approval update packet at the end of your approval period?
   ☐Yes ☐No

3. **PLEASE SPECIFY FACILITY TYPE AND PERCENTAGES OF PRACTICE AREAS BELOW:**

% SMALL ANIMAL	% FOOD ANIMAL	% AVIAN	% LAB ANIMAL	% Z00/ EXOTIC	% PUBLIC HEALTH	% EQUINE	% OTHER

☐ Clinic/Hospital ☐ Mobile Practice ☐ Emergency Facility ☐ Research Facility ☐ Humane Society ☐ Specialty Facility

Patient Caseload Statistics

1. Approximate number of: outpatients seen daily: _____ hospitalized patients daily: _____
2. If practice has areas of specific interest, please list:
   _____ _____
   _____ _____
3. If practice has Board certified personnel, please list:
   _____ _____
   _____ _____

Practice Management

1. Is your practice computerized? ☐Yes ☐No
2 Are individual records kept for each animal or herd? ☐Yes ☐No
3. How long are records kept? _____
4. Are records made available upon client's request? ☐Yes ☐No

Pharmacy

1. Is drug inventory monitored? ☐Yes ☐No
2. Are prescription records kept? ☐Yes ☐No
3. Is a controlled drug log kept? ☐Yes ☐No
4. Do you use: prescription labels? ☐Yes ☐No
   safety dispensing vials? ☐Yes ☐No
5. Are legend drugs dispensed only when a valid veterinarian-client-patient-relationship exists? ☐Yes ☐No

Hospital Facilities (For other than bovine & equine practices)	Yes	No	Number
1. Does practice have hospitalization facilities? If yes, complete this section:			
Number of examination rooms			
Number of cages and runs			
2. Does hospital have an isolation ward (controlled contamination)?			
3. What percentage of animals which die in the hospital are necropsied?			
4. Do you have oxygen therapy available in the hospital?			

Surgeries & Anesthesia

1. Does your practice routinely require client's signature for anesthesia and/or a surgical release form? ☐Yes ☐No
2. Are patients examined prior to surgery (within 12 hours)? ☐Yes ☐No
3. Do you use inhalation anesthesia? ☐Yes ☐No
   List type(s) used: _____
4. What other forms of chemical restraint do you use? _____
5. What means of monitoring patient heart and respiration do you use during anesthesia? _____
6. Do you have the following?
   - A surgery room separate from the examining room(s) ☐Yes ☐No
   - A surgical preparation area separate from the surgery room ☐Yes ☐No
7. Do you perform the following surgeries?
   - Routine/ovariohysterectomy/castrations ☐Yes ☐No
   - Intrathoriacic ☐Yes ☐No
   - Orthopedic/basic; i.e. pinning ☐Yes ☐No
   - Orthopedic/advanced; i.e. plating ☐Yes ☐No
   - Ophthalmic ☐Yes ☐No
   - Neurosurgery ☐Yes ☐No
8. Indicate in the columns below which items you use for the surgeries given:

	Minor Surgeries		**Abdominal Surgeries**		**Orthopedic Surgeries**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
SURGICAL SCRUB						
MASK						
CAP						
GLOVES						
GOWN						
AUTOCLAVE PACK						
ANESTHESIA ASSISTANT						
SURGICAL ASSISTANT						

Laboratory

1. For each procedure listed below, indicate the approximate number performed in an average week:

	OFFICE LAB	OUTSIDE LAB		OFFICE LAB	OUTSIDE LAB
BACTERIAL CULTURES & SENSITIVITIES			HEMOGRAM (CBC)		
CHEMISTRY PROFILES			SEMEN ANALYSIS		
CYTOLOGY			OTHER SEROLOGY		
FECAL FLOTATIONS			URINALYSIS		
HEARTWORM SCREEN OCCULT			DTM		

Radiographic Equipment

1. Do you have or use the following:

Radiograph (x-ray) equipment? ☐Yes ☐No

Leaded gloves? ☐Yes ☐No

Leaded aprons? ☐ Yes ☐No

Film badges? ☐Yes ☐No

Film Identification? ☐ Yes ☐No

Contrast Procedures?

(barium studies, myelograms, etc.) ☐Yes ☐No Type: _____

Surveyed by State/Local Safety Inspectors? ☐Yes ☐No Date: _____

2. How long are films kept? _____
3. Average number of radiographs taken weekly.

Small animal - _____ number Large animal - _____ number

Miscellaneous

1. Do you have an EKG machine? ☐Yes ☐No

If yes, how many EKGs do you average per week? _____

2. Do you have other diagnostic equipment available (ultrasound, endoscopy, etc.)?

☐Yes ☐No

If yes, please list type and average use per week (number of cases) in the following chart:

TYPE	NUMBER

3. How are after-hour emergencies handled in your practice?

_____

_____

4. Does your practice include ambulatory service? ☐Yes ☐No

If yes, please complete the following: Number of ambulatory vehicles: _____

Approximate mile radius covered: _____

Average number of ambulatory calls weekly: _____

5. **If there is any other information you feel would be of use to a preceptee in selecting your practice for preceptorship, please attach that information to this assessment questionnaire.**

Preceptee Job Description - for permanent filing

PRACTICE NAME: _____ City/State _____

In this section, list the basic information and procedures you plan to cover with a preceptee (DVM applicant). ALL areas listed are required by our program. Approvals are contingent in part upon this information.

ADMINISTRATIVE EXPERIENCES	
MANAGEMENT	
FINANCIAL ACTIVITIES	
PERSONNEL SUPERVISION	
CLIENT RELATIONS	

MEDICINE AND SURGERY Indicate activities in which preceptee will be involved and describe briefly any special circumstances, equipment or restrictions which will apply. The preceptee must be allowed hands on experience in these areas, (if available). Use separate sheet if necessary.	
PRE-OP PATIENT PREPARATION	
ANESTHESIA	
SURGERIES	
POST-OP PATIENT CARE	
CLINICAL LABORATORY & DIAGNOSTIC PROCEDURES	
PREVENTATIVE MEDICINE PROCEDURES	
GROSS NECROPSY	
RADIATION SAFETY (USE OF GLOVES, APRON, BADGE, ETC.)	
OTHER (Describe any activities not listed above)	

Expires _____ Approval Status: **Full / Limited**

Staff Information

- Approval of a practice is based upon the facility and the professional staff available to supervise the student/ preceptee.
- Please list below all veterinarians on your staff and give complete information on each.
- Changes in staff should be reported to the Louisiana Board of Veterinary Medicine.
- If you regularly employ relief veterinarians, please give information requested for that person or persons.
- Please note that the Board requires a supervising veterinarian to have at least three years clinical experience.

STUDENTS WHO ARE SUPERVISED BY UNAUTHORIZED (UNAPPROVED) PERSONNEL MAY NOT BE GIVEN CREDIT FOR THE TIME SPENT WITH THAT PERSON.

1. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	
2. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	
3. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	
4. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	

5. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	

6. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	

7. NAME OF VETERINARIAN		MEMBER OF: ☐ AVMA ☐ LOCAL ASSOCIATION ☐ STATE ASSOCIATION	☐ OWNER ☐ ASSOCIATE ☐ RELIEF
YEAR GRADUATED:	YEARS IN PRACTICE:	WILL THIS DVM SUPERVISE STUDENT/PRECEPTEE? ☐ Yes ☐ No	
SPECIALTY MEMBERSHIPS, DIPLOMATE, CERTIFICATIONS, ETC.		HAS THIS DVM HAD ANY DISCIPLINARY ACTION TAKEN BY ANY BOARD IN THE PAST FIVE YEARS? ☐ Yes ☐ No If yes, submit details of disposition on separate sheet of paper. This information is for the use of the Board only.	

PLEASE USE SEPARATE PAGE IF ADDITIONAL SPACE IS NEEDED.

This form is to be mailed directly to the Louisiana Board of Veterinary Medicine at:
301 Main Street, Suite 1050, Baton Rouge, Louisiana 70801

Signature of Practice Owner: _____ Date: _____

Signature of Supervising DVM (if different) _____ Date: _____

Thank you for your interest in this program of the Louisiana Board of Veterinary Medicine.
Your participation is greatly appreciated.

FOR OFFICE USE ONLY:	**REVIEWED BY:**	**APPRVD**	**APPRVD W/Cmts**	**NOT APPRVD**	**NOT APPRVD REASONS**	**COMMENTS**
Reviewed date:						

Revised 5/2020

SAMPLE – Job Description - SAMPLE

In this section, list the basic information and procedures you plan to cover with your preceptee. ALL areas listed are required by our program. Approvals are contingent in part on this information.

ADMINISTRATIVE EXPERIENCES	
MANAGEMENT	Relate own experience in meeting sales representative, reviewing drug costs, monitoring inventory, logging in drug and supply shipments, and review expenses.
FINANCIAL ACTIVITIES	Explain P&L statements and finances in hospital/clinic operation; explain importance of bank relations, credit and overhead; exposure to cost/expense factors in determining fees and price structure.
PERSONNEL SUPERVISION	Explain importance of patience, understanding and firmness; scheduling of staff; attendance of staff meetings; provide training to staff but in no supervisory capacity.
CLIENT RELATIONS	Greet clients; assisting in record filing; exposure to clients and working with them in examining rooms; assist in history taking; importance of good communication skills.

MEDICINE/SURGERY Indicate activities preceptee will be involved in and describe briefly any special circumstances, equipment or restrictions which will apply. The preceptee must be allowed hands on experience in these areas, (if available). Use separate sheet if necessary.	
PRE-OP PATIENT PREPARATION	Responsible for pre-op procedure checklist; determine dosage for pre-anesthetic, administering, and monitoring animal.
ANESTHESIA	Monitor anesthetic and vital signs.
SURGERIES	Assist with surgeries with exposure to all surgical procedures; wound prep and suture selected wounds under supervision; perform selected surgeries depending on individual's ability.
POST-OP PATIENT CARE	Responsible for in-patient care; watch for signs of pain and administer analgesics; watch for normal recovery; good records a must.
CLINICAL LABORATORY & DIAGNOSTIC PROCEDURES	Allowed to perform in-house test under supervision, QBC, chem panels, UA, cytology of skin and ears, needle aspirates, impression smears of masses, etc.; consult on interpretation; encourage diagnostic opinions of preceptee.
PREVENTATIVE MEDICINE PROCEDURES	Administer vaccines, collect blood and fecal, perform HW exams under supervision; give presentation to staff at local humane society on infectious disease.
GROSS NECROPSY	Assist or perform under supervision.
RADIATION SAFETY (USE OF GLOVES, APRON, BADGE, ETC.)	Be required to use routine safety equipment.
OTHER (Describe any special activities not listed above)	Animal restraint, care and use of equipment, telephone skills, public relations, etc.