Intent to Begin Clinical Training – Midwifery Program

Filling out this form does not register you for Clinical Training Credit. Please complete and submit this form to the front office. If you have questions about this form or the clinical training process, contact the Midwifery Program Coordinator or the Faculty Coordinator.

Student Information:

Legal First Name	Middle Initial	Legal Last Name

- **Supervising Preceptor:** An approved primary supervisor for the student as they complete clinical training.
- **Co-preceptor:** An approved preceptor in the same practice and at the same clinical site as the Supervising Preceptor, who may sometimes supervise the student in clinical training.

Intended Supervising Preceptor – clearly print their full name	**Practice Name**
Clinical Training Site Address:	

Co-Preceptor(s) – (if applicable) – please clearly print their full name(s)

Intended date to begin Clinical Training:_____

Please initial and sign below:

____ I understand that I cannot work with an unapproved preceptor and that the preceptor approval process may take a month or more from the time this form is submitted.

____ I understand that if my preceptor is an unlicensed midwife in the state of Oregon it is illegal for them to carry or use Legend Drugs and Devices (LD&D) unless they are under a physician's supervision. To do so is considered practicing medicine without a license, which is a felony in the state of Oregon. I understand that I must report a preceptor who uses unauthorized drugs and devices to Birthingway College of Midwifery.

____ If I plan to work with an unlicensed midwife I am aware that MEAC requires students to have access to appropriate equipment and supplies while working with preceptors. Students may not receive experience observing and participating in the usage of LD&D while working with an unlicensed preceptor, unless that preceptor is under the supervision of a licensed physician.

____ I understand that the clinical training site may have their own policies/procedures (particularly in a hospital setting) which I will need to follow.

_____

Student Signature Date

Office Use Only	**Date/Time/Initial:**
Please route in this order: ____ FAC ____ REG ____ MPC ____ FAC (file)	
REG	**Student completion of first-year Core and Fetal Assessment verified by REG _____**
FAC	**Preceptor(s) approved on:**
	Preceptor(s) approval pending:
	Student notified of Preceptor approval or denial on: