

Idaho College of Osteopathic Medicine

Preceptor Application

Full Name: _____

Specialty: _____

Credentials: _____

Email: _____

Date of Birth: _____

Office phone #: _____

Cell phone #: _____

Text messages approved: Yes: _____ No: _____

Preferred Office Contact #
and email address: _____

Mailing Address: _____

Office Address:
(if different from mailing) _____

Medical License #:
Stated and Date Issued: _____

Board Certification:
Board Eligible: _____

CME Reporting:	MD: certificate/self-report
-AOA 1B credit (DO)	DO: AOA/report on my behalf: AOA# _____
-PRA Category 2	DO: Certificate/self-report

***IMPORTANT:** Please provide verifying documentation of your Medical License and Board Certification along with this completed application.

Please answer the following questions:

1. Has your license to practice medicine in any jurisdiction ever been refused, limited, suspended, or revoked? **Yes:** **No:**
2. Has your privileges at any hospital ever been refused, limited, suspended, revoked, diminished, or non-renewed? **Yes:** **No:**
3. Has your DEA registration or State controlled substance certificate ever been limited, suspended, or revoked? **Yes:** **No:**
4. Have you ever been convicted of a misdemeanor or a felony (other than a minor traffic violation)?
Yes: **No:**
5. If you answered "Yes" to any of the above questions, please explain.
If you answered "No", please enter "N/A".

In terms of medical education, what are your areas of interest? How do you envision yourself interacting with ICOM students?

Payment Information Form and Appointment Request:

Payment:

Direct Deposit and Check Payment Process:

Please provide your information via our secured link and application that will take you a form via Monday.com website no unique credentials are required to access the form – [Preceptor Payment Form](#)

- Please note: We cannot pay you for your services until this information is received
- The final question asking for your eValue number is not required and applies to current preceptors requesting change to their current payment information.

Attestation: I confirm I have completed the above "Preceptor Payment Form:"

Yes: _____

(Signature / Date)

Comments (optional):

ICOM Preceptor Appointment Title Request:

Are you requesting to receive an ICOM Appointment title: Yes: (please see below) No:

***IMPORTANT:** Appointment is not a requirement to precept ICOM students or to be paid as a preceptor.

Available ICOM Preceptor Appointment titles:

1. **Adjunct Clinical Faculty of (specialty)**

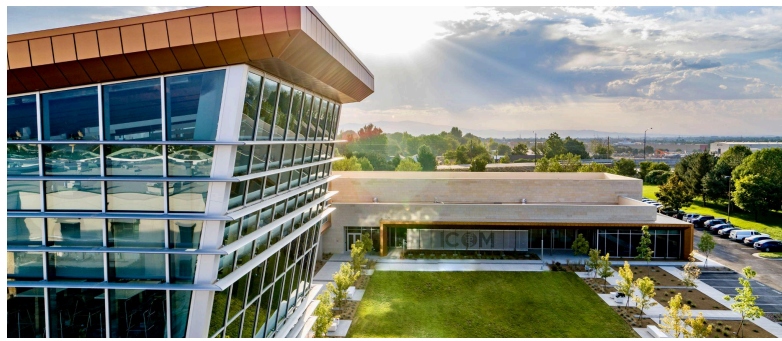
- There are no prerequisites for this appointment title

2. **Adjunct Associate Professor of (specialty)**

- This is a promotional title and must be approved through our promotions committee with the following requirements:
 1. A previous school appointment title with verification
 2. A full and up-to-date CV

Disclaimer: ICOM Appointment title requests vary in time to be fully processed and you will receive further communication if additional information is requested.

-END-



ICOM Clinical Rotation Block Schedule

Academic Year 2026-2027

Block 1:	July 1-July 24, 2026
Block 2:	July 27-August 21
Block 3:	August 24-September 18
Block 4:	September 21-October 16
Block 5:	October 19-November 13
Block 6:	November 16-December 11
Block 7:	December 14-January 8, 2027
Block 8:	January 11-February 5
Block 9:	February 8-March 5
Block 10:	March 8-April 2
Block 11:	April 5-April 30
Block 12:	May 3-May 28
Block 13:	May 31-June 25

Clinical Affairs Deans



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