



Kentucky College of Osteopathic Medicine

ADJUNCT FACULTY AFFILIATION AGREEMENT

Thank you for your interest in becoming an adjunct faculty with the University of Pikeville - Kentucky College of Osteopathic Medicine! The attached paperwork will assist our staff in your appointment. We will need additional items from you along with this paperwork:

- Attached Adjunct Faculty Affiliation Agreement
- Current CV
- Face Copy of your Malpractice Insurance
- Copy of your Current Medical License
- Background Check (no cost to you) or verification from your facility's Human Resources office stating you have had a background check.
- W9

University of Pikeville – Kentucky College of Osteopathic Medicine

Physician Affiliation Agreement

This agreement with the University of Pikeville and its Kentucky College of Osteopathic Medicine (hereafter KYCOM), is solely intended to provide educational training opportunities for KYCOM students. With this affiliation, I agree to the appointment as a KYCOM Adjunct Clinical Faculty or Guest Lecturer effective from the date signed below.

I understand that with the acceptance of this Agreement, I will assist KYCOM in providing training for the osteopathic medical students on-campus and/or at off-campus affiliated clinical sites. I agree to follow the curriculum provided by KYCOM, and also agree to review, monitor, and provide feedback for revision of the curriculum as needed; however, in contrast to an employee of the University, I am not responsible for preparation of syllabi or oversight of any course, nor am I expected to participate in faculty meetings or committee responsibilities unless specifically invited by KYCOM Administration.

On a fiscal quarterly basis, KYCOM will distribute quarterly honorariums to each individual (or facility if required) who has completed all paperwork, including student evaluations in Medtrics, and/or provided lectures to osteopathic medical students, including the submission of exam questions pertinent to the lectures, if applicable. KYCOM will issue an honorarium for core and selective rotations completed by KYCOM students. The rate or amount of the honorarium for teaching is outlined on page four of this agreement. KYCOM may update this rate or amount of the honorarium from time to time upon written notification.

I acknowledge that for the purposes of this Agreement and Addendum, I am an independent contractor, not a University or KYCOM employee, and therefore not entitled to benefits including, but not limited to, health insurance, workers' compensation, and unemployment insurance. As an independent contractor, I furthermore agree and understand that I am solely responsible for my own taxes (including any tax consequences, penalties, and fees resulting from payment to me under this Agreement) and will be required to complete and update an IRS W-9 Form, and any other required documentation, to receive financial compensation. In addition, I reserve the right to forfeit payment at this, or anytime in the future, by not providing a fully completed IRS W-9 Form, or by providing written documentation of forfeiture to the KYCOM Dean's Office.

I also acknowledge I may be subject to additional terms and conditions while working with KYCOM students, if I am associated with or employed by a medical practice or facility with its own affiliation agreement with KYCOM, and agree to consult with my practice or facility, if applicable, concerning such terms and conditions.

When applicable, upon the completion of each student clinical rotation, I agree to complete the student's online Medtrics evaluation form within 30 calendar days of it being sent to me. In addition, I acknowledge and agree that I will not receive either payment or

University of Pikeville – Kentucky College of Osteopathic Medicine

CME credit (if applicable) for the clinical rotation until the student evaluation is completed in the Medtrics system. I also understand that an evaluation of me, and my teaching, will be required from students whom I teach. Evaluations are one aspect of the continual faculty assessment process at KYCOM, and I should expect to receive feedback from this evaluation process. I further understand that I am encouraged to contact KYCOM at any time regarding current, past, or future students, curriculum, or with any questions or comments regarding grading or educational procedures.

My signature below affirms that I am duly licensed to practice medicine or osteopathic medicine in at least one jurisdiction, and I will at all times maintain medical malpractice insurance of at least \$1,000,000/\$3,000,000 coverage. As a result of this Affiliation with the University and KYCOM, I agree to undergo a required University of Pikeville background check; abide by the University's policies on Sexual Misconduct, harassment and discrimination, and the Family Educational Rights and Privacy Act ("FERPA"); and will fully cooperate with university investigations and actions regarding allegations of non-conformity to these policies and laws. I agree to notify KYCOM immediately of any change in my practice status or professional credentials.

I agree to conduct any clinical teaching responsibilities under this Agreement consistent with KYCOM's manual and policies on clinical rotations, as may be amended from time to time and understand KYCOM will endeavor to provide me with updated copies of the same. I understand that KYCOM will provide me in advance with a list of the students I am being asked to precept in the clinical setting, and that I will be asked to approve the schedule of student clinical rotations. I may, at my discretion, make needed changes in my availability for teaching by contacting KYCOM in writing at least 20 business days prior to the change. I understand that I have the right to refuse any student(s) for lawful purposes by notifying the KYCOM Office of Clinical Affairs; however, once accepted, it is imperative that the Office of Clinical Affairs has early and prompt notice of any schedule or availability changes. This agreement in no way obligates KYCOM to provide any specific number of students during any specific period of time.

This agreement and Adjunct Clinical Faculty or Guest Lecturer appointment is for a term of three (3) academic years from the date of signature, but may be terminated, or not renewed, by either party without cause upon 90 calendar days written notice. I acknowledge this Agreement supersedes and replaces any prior Agreements, negotiations, and discussions between KYCOM and me concerning the subject matter addressed in this Agreement.

University of Pikeville – Kentucky College of Osteopathic Medicine

Name _____

Specialty _____ **Board Certified or Board Eligible** (please circle one)

Home Address _____

Office Mailing Address _____

Cell Phone Number _____

Office Telephone Number _____

Email Address _____

Payment for each four-week Core or Selective rotation shall be: \$ 1,000.

Payment for each lecture shall be \$160.00.

Pay to: Physician Affiliated Hospital (add name below) Waive Honorarium

Name of Affiliated Hospital/Institution: _____

Physician must indicate whether payment is to be paid directly to physician, to affiliated hospital, or waived!

Physician:

Name (Please Print)

Signature

Date ____/____/____

For KYCOM:

Maleshea Hopkins, D.O.
Associate Dean of Clinical Affairs
147 Sycamore Street
Pikeville, Kentucky 41501

Signature

Date ____/____/____

***** Website link to initiate your background check will be sent separately to the email address listed above and must be completed for appointment. *****

Request for Taxpayer Identification Number and Certification

Go to www.irs.gov/FormW9 for instructions and the latest information.

Give form to the
requester. Do not
send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)		
	2 Business name/disregarded entity name, if different from above.		
	3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) _____ Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____	4 Exemptions (codes apply only to certain entities; not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ <i>(Applies to accounts maintained outside the United States.)</i>	
	3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions _____ <input type="checkbox"/>		
	5 Address (number, street, and apt. or suite no.). See instructions.	Requester's name and address (optional)	
	6 City, state, and ZIP code		
	7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

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Part II Certification

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
- I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
- I am a U.S. citizen or other U.S. person (defined below); and
- The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they