



## University of Chicago Celiac Disease Center PRECEPTORSHIP IN CELIAC DISEASE

### ***Introduction***

The University of Chicago Celiac Disease Center preceptorship is designed for gastroenterologists, primary care physicians and nurse practitioners who want to develop or expand their expertise in celiac disease.

The overall goal of the program is to provide quality education and exposure to managing patients with Celiac Disease under the direction of expert faculty. A curriculum for this program has been designed to meet educational and credentialing goals to provide a condensed, but comprehensive training program.

### **Application**

Please complete the following questions:

1. Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: State: Zip Code: \_\_\_\_\_

Office Number: \_\_\_\_\_

Pager Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_



**2. Are you a:  
Primary Care Physician?**

Private Practice \_\_\_\_\_ Academic Practice \_\_\_\_\_ Number of years in practice? \_\_\_\_\_

**Gastroenterologist?**

Private Practice \_\_\_\_\_ Academic Practice \_\_\_\_\_ Number of years in practice? \_\_\_\_\_

**Nurse Practitioner?**

Private Practice \_\_\_\_\_ Academic Practice \_\_\_\_\_ Number of years in practice? \_\_\_\_\_

**GI Fellow?**

In year number: \_\_\_\_\_ of \_\_\_\_\_ years

Program Director: \_\_\_\_\_

**Other?**

Please describe: \_\_\_\_\_

\_\_\_\_\_

How many physicians are in your practice? \_\_\_\_\_

How many patients are seen on average in your practice per week? \_\_\_\_\_

How many of those are:

pediatric (1-17 years old) \_\_\_\_\_ adult (above 18) \_\_\_\_\_

**3. What is the complete name and address of your primary hospital?**

\_\_\_\_\_

\_\_\_\_\_

**4. Please list States in which you are licensed to practice.**

\_\_\_\_\_

**5. Have you had any additional training in celiac disease?**

Type and duration of training \_\_\_\_\_

Institution \_\_\_\_\_



**6. How many new celiac patients do you see in one month?**

- None
- 1-2
- 3-5
- 6-8
- More than 8

**How many celiac patients in total are followed in your practice?** \_\_\_\_\_

**7. How far are you from the nearest tertiary center for referrals of celiac patients?**

\_\_\_\_\_  
**Name of center:** \_\_\_\_\_  
\_\_\_\_\_

**8. How did you become aware of the existence of the University of Chicago Celiac Disease Center?** \_\_\_\_\_  
\_\_\_\_\_

**9. What is your primary reason for committing to additional training?**

\_\_\_\_\_  
\_\_\_\_\_

**Additional Documentation**

This application must be completed and sent to The University of Chicago Celiac Disease Center along with the following documents:

- A current CV
- A letter of support from the Director of the Fellowship Program for Pediatric GI Fellows or from the supervisor of the Nurse Practitioner at the hospital where you have privileges.

Please allow 4 to 6 weeks for application process and decision status.

Fax, e-mail or send application and documents to:

**Celiac Disease Preceptorship**

**University of Chicago Celiac Disease Center**

**5839 S. Maryland Avenue, MC 4069**

**Chicago, IL. 60637**

**FAX: 773-702-0666**

**e-mail: [cshilson@bsd.uchicago.edu](mailto:cshilson@bsd.uchicago.edu)**