

**APRN Student Clinicals Application**

**Student Information** *(you may tab through this form to fill it.)*

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| **Name:** |  | **Cell Phone:** |  |
| **Preferred Email:** |  | **Secondary phone:** |  |
| **Alternate Email:** |  |
| **Street Address:** |  |
| **City, State, Zip:** |  |
| **Hometown:** |  |
| **Licensure/State:** |  |
| **EDUCATION** |  |
| **Name of Current School:** |  |
| **City, State:** |  |
| **Anticipated Date of Graduation (Month/Year):** |  |
| **Undergraduate School Attended:** |  |
| **City, State:** |  |
| **Year Graduated:** |  |
| **Major:** |  | **Degree:** |  |
| **Other Undergraduate School Attended:** |  |
| **City, State:** |  |
| **Year Graduated:** |  |
| **Major:** |  | **Degree:** |  |
| **High School Attended:** |  |
| **City, State:** |  |
| **Year Graduated:** |  |
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| **REQUEST for Clinicals** |
| Rotation name | ***# required hours*** | ***Dates of clinical rotation***  | ***Student schedule in clinic*** |
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| Please attached a bio and photo |

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| **Membership in Professional Societies:** |

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| **What experience do you have in clinicals so far? (Dates, Number of Hours, Discipline, Location)** |

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| **What are your reasons for applying for clinicals at Phelps Health?** |

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| **Are you currently planning to practice in a rural/underserved community after your graduation?** |

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| **Additional Comments:**   |

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| **Signature:** |  | **Date:** |  |