NMC health

APPLICATION FOR CAPSTONE / OBSERVATION / STUDENT PRACTICUM

Please complete application. Return all paperwork to the Nursing Administration Office or Education Coordinator for processing.

Mailing Address:	600 Medical Center Drive PO Box 308 Newton, KS 67114	robyn.davis@mynmchealth.org Ph: 316-804-6005 Fax: 316-804-6260	jennifer.fernandez@mynmchealth.org Ph: 316-283-2700, ext. #3710 Fax: 316-804-6268

PRIVILEGES REQUESTED

☐ BSN ☐ BSN to MSN ☐ CNA ☐ Observer ☐ Other______________ ☐ RN ☐ RN to BSN
☐ Surgical Tech

APPLICANT: Please complete information below and provide copy of current license, if applicable.

Type of Program: ____

License #: ______________________________ Expiration Date: ________________ ☐ N/A

PERSONAL IDENTIFICATION INFORMATION

Applicant (first, middle, last): ______________________________ Date of Birth: ____________

Home Address (street, city, state, zip): ______________________________________

Home Phone: ________________________ Cell Phone: ________________________

Emergency Contact: ________________________ Relationship: ________________________

Home Phone: ________________________ Cell Phone: ________________________

SCHOOL/PROGRAM INFORMATION

School Affiliation: ______________________________________

Address (street, city, state, zip): ______________________________________

Program Contact: ________________________ Phone: ____________________

Date of Program Completion: ______________________________________

Supervising/Practicum Coordinator: ______________________________________

Rotation Dates Requested: From: ______/ _____/_______ To: ______/ _____/_______

Estimated Total # of Rotation Hours: # ________________hours

CLINICAL PRACTICUM REQUIREMENTS

Documentation of the following <u>must</u> be submitted with your application–NMC may administer Flu and TB if incomplete:

- ☐ Clinical CPR certification, if applicable
- ☐ Criminal background check on file at affiliated program or place of employment, if applicable
- ☐ Health insurance, if applicable
- ☐ Influenza Vaccine (*documentation required per hospital specific dates*)
- ☐ Liability insurance, if applicable
- ☐ TB skin test
- ☐ COVID-19 Vaccination/Exemption Status

By signing below I attest that I have had the following immunizations:

- ☐ MMR Immunization or Titer
- ☐ Series of 3 Hepatitis B Vaccines or Titer
- ☐ Td/tdap Booster within the Last 10 Years
- ☐ Varicella Vaccine (or a Positive History of Chickenpox) or Titer

Signature: ______________________________________ Date: ____________

OFFICE USE									
Badge with computer access	☐Yes	☐No	☐N/A	Date ______/Int____	ID verified, if applicable	☐Yes	☐No	☐N/A	Date ______/Int____
Badge issued	☐Yes	☐No	☐N/A	Date ______/Int____	License verified, if applicable	☐Yes	☐No	☐N/A	Date ______/Int____

	Badge returned	☐Yes	☐No	☐N/A	Date ______/Int____	IS registration complete	☐Yes	☐No	☐N/A	Date ______/Int____
	Community benefit hrs recorded	☐Yes	☐No	☐N/A	Date ______/Int____	Photo consent, if applicable	☐Yes	☐No	☐N/A	Date ______/Int____
	Confidentiality statement	☐Yes	☐No	☐N/A	Date ______/Int____	Process complete/filed	☐Yes	☐No	☐N/A	Date ______/Int____

NOTE: ____

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