ADVANCED PRACTICE REGISTERED NURSE STUDENT APPLICATION

FOR EXPERIENCES REQUIRING PHYSICIAN SUPERVISION

For **INPATIENT** AdventHealth Orlando hospital permissions, submit to: Heather.Hernandez@AdventHealth.com You may search for a preceptor by specialty at www.AdventHealthOrlando.com. If you are requesting Nursing Education, Nursing Informatics or Nursing Management, please contact Nursing Education/HR Regulatory Services Alexis.Wharton@AdventHealth.com.

For **INPATIENT with AdventHealth Medical Group (AHMG) PRECEPTORS or "AHMG at Orlando" locations and OUTPATIENT AHMG CFD-S** submit to: Caryl.Gunawardena@AdventHealth.com. AHMG does not schedule on behalf of students. You may search by specialty for a preceptor at www.AdventHealthMedicalGroup.com.

Academic affiliation agreements must be fully executed and will be verified and as part of the onboarding process prior to providing clinical permissions. If you have ever observed, volunteered or worked at Florida Hospital or AdventHealth, please provide your username (OPID) or let us know there should be one on file. Instructions regarding online training and obtaiing a badge will be emailed after agreement and preceptor approval is confirmed.

PROGRAM	☐ **NEW STUDENT/FIRST ROTATION**	☐ **RETURNING STUDENT**
☐ Advanced Practice Registered Nurse (APRN)	☐ Doctor of Nursing Practice (DNP)	
☐ Certified Nurse Midwife (CNM)	☐ Other (Specify):	
☐ Master of Science in Nursing (MSN)	Do you pan to continue with an additional degree? ☐ Yes ☐ No ☐ Maybe	

APPLICANT INFORMATION	Date:	
Last Name:	First Name:	Middle:
Gender Male ☐ Female ☐ Other ☐ DOB:	SSN:	Full SSN is required
School Issued Email Address:	Emergency Contact Name:	
Cell Phone:	Emergency Contact Phone:	
Have you ever had an AdventHealth OPID? Y ☐ N ☐ OPID:	Department/Unit (if employed):	
Expected Graduation Date (MM/DD/YYYY):		

SCHOOL/PROGRAM CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORRESPONDENCE/AFFILIATION AGREEMENT/EVALUATION)			
School/Program Name:	School Abbreviation:		
Contact Name:	Title:		
Street Address:	City:	State:	Zip
Business Phone:	Email:		

TRAINING STATEMENT

Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting?
☐ No ☐ Yes, Please Explain:

DISCLAIMER AND SIGNATURE

I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents, as indicated in this application, including any additional documents as requested by the AdventHealth. I agree to obtain prior written approval of AdventHealth before publishing any material related to the learning experience provided.

Applicant Signature:	Date:

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☐ Inpatient ☐ Outpatient ☐ AHMG at Orlando

NAME OF ROTATION: Total Hours:

Semester Dates: Start (MM/DD/YYYY): End (MM/DD/YYYY): Graduation

LOCATION: (select all that apply): ☐ AdventHealth Orlando ☐ AdventHealth for Women ☐ AdventHealth for Children ☐ AdventHealth Altamonte Springs ☐ AdventHealth Apopka ☐ AdventHealth Celebration ☐ AdventHealth East Orlando ☐ AdventHealth Kissimmee ☐ AdventHealth Winter Garden ☐ AdventHealth Winter Park ☐ AHMG Clinic

Student Name:	Student School Name:

ADVENTHEALTH PRECEPTOR INFORMATION

MUST BE INCLUDED PRIOR TO SUBMITTING

I am a healthcare provider with an unrestricted license to practice in my specialty, and a current member of AdventHealth Medical Staff. By my signature below, I agree to precept the Student named above in a clinical rotation during the requested dates on this application. I assume full responsibility for the education, evaluation, conduct and actions of the student while on rotation.

Last Name:	First Name:	M.I.:	Credentials:

Employer: ☐ AdventHealth Orlando ☐ AdventHealth Medical Group ☐ Other:

Specialty:

Primary Hospital/Practice Name:

Inpatient Unit/Department:

Practice Address:

Signature:	Email:

Supervising Physician/Preceptor Approval Employer:

Name:	Title:
Signature:	Date::

Inpatient Unit Director Approval ☐ *Not Applicable – No Inpatient Experience*

Name:	Title
Signature:	Date:

Practice Manager/Leader Approval ☐ *Not Applicable – No Outpatient Experience*

Name:	Title:
Signature:	Date:

Submit both pages of complete application with start and end dates and all signatures at least two weeks prior to start date to:

Heather Hernandez, AdventHealth Orlando | Graduate Medical Education Administration
Heather.Hernandez@AdventHealth.com

Caryl Gunawardena, AdventHealth Medical Group Central Florida Division | Clinical Quality Improvement and Excellence
Caryl.Gunawardena@AdventHealth.com