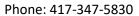
Email: professionaldevelopment@freemanhealth.com





## **Professional Development**

## Advanced Practitioner Student Application

Paramal Information Drint on True					
Personal Information: Print or Type					
SSN (Full):	Date of birth:				
Name:			3 61 1 11		
Last	First		Middle		
Current Address:					
Current Address: Street	City		State	Zip	
		* 7	<b>N</b> 7	•	
Phone #:	Ok to text:	Yes	No		
Email:					
Eman.				<del></del>	
School/Program Name/Grad Date:					
	nool/Program Nan	ne	Gra	aduation Date	
	_				
<b>Specialty Seeking:</b> Nurse Practitioner Phys	sician Assistant	CRN	NA Nur	se Midwife	
School Coordinator's Name & Contact Info:					
<b>Current Freeman Employee:</b> Yes No	Former Freen	nan Em <sub>l</sub>	ployee: Yes	No	
Rotations Requested: We will do our best to match	• •		_ ·		
Requested Specialty & Preceptor Name (if known	n) Start Date	9	End Date	Req. # of Hours	
1.					
2.					
3.					
3.					
4.					
5.					
Freeman Health System requires the following info	ormation along wi	th vour a	application at	least 45 days prior to the	
scheduling of your rotation. We reserve the right to					
timely.	·				
All applicants must provide the following:		Additional documents for <b>non</b> -Freeman employees:			
□ Rotation application		☐ Attestation from school that includes that student has met			
☐ Letter of good standing from school	-	the requirements listed in the affiliation agreement:			
☐ Proof of liability insurance		-Vaccination/declination for MMR, TB, Hep B, COVID, and Flu			
□ Photo ID in JPEG format	-Comprehensi	-Comprehensive Criminal Background Check			
□ Copy of evaluation needed for school	-Drug Screen		-		
☐ Copy of BLS certification, ACLS may be required					
depending on specialty requested					
		_			
Student Signature				Date	