



Clinical Student Application

Area of Focus for Practicum: Adult Health Women's Health
 Pediatrics Behavioral Health
Practicum Start Date: ___/___/___ End Date: ___/___/___
Hours Needed: _____

APPLICANT INFORMATION

Name: _____ Date: ___/___/___
First MI Last

Address: _____
Street Address Apartment/Unit #

City State Zip Code

Phone: () _____ Email: _____

EDUCATION AND EXPERIENCE

School Attending: _____ Phone: () _____

Expected Graduation Date: ___/___/___ Specialty/Specialties: _____

School Address: _____
Street Address

City State Zip Code

Clinical Professor/Staff Member: _____ Contact Number: () _____

School Contact: _____ Contact Number: () _____

Clinical Start Date: ___/___/___

Clinical End Date : ___/___/___

Specific Days and times that clinicals will be completed: Monday ___ AM to ___ PM
 Tuesday ___ AM to ___ PM
 Wednesday ___ AM to ___ PM
 Thursday ___ AM to ___ PM
 Friday ___ AM to ___ PM

List any previous clinical references, beginning with the most recent:

1. Clinic/Site: _____ Phone: () _____

Name of Preceptor: _____ Adult Health Women's Health

Practicum Dates: From ___/___/___ - ___/___/___ Hours completed: _____

2. Clinic/Site: _____ Phone: () _____

Name of Preceptor: _____

Adult Health Women's Health

Practicum Dates: From ____ / ____ / ____ - ____ / ____ / ____

Hours completed: _____

3. Clinic/Site: _____

Phone: (____) _____

Name of Preceptor: _____

Adult Health Women's Health

Practicum Dates: From ____ / ____ / ____ - ____ / ____ / ____

Hours completed: _____

PRACTICUM SCOPE

Briefly describe two learning goals you wish to achieve during this practicum:

1. _____

2. _____

Briefly describe one career goal you wish to achieve:

1. _____

Briefly explain why you are interested in completing your clinical hours at MVHC:

1. _____

PROCESS AND PROCEDURE

Step 1: Mail, email or fax completed application to MVHC.

Step 2: Applications are forwarded to scheduler.

Step 3: **MVHC will contact the applicant should something become available.**

Please review and sign below stating your understanding.

You will have to attend an EPIC computer training class with us, you will **NOT** be allowed to start precepting with MVHC until you do so. We hold them once a month towards the end of each month. It is required that you attend the EPIC training class one month before you start. Example: Start date of 08/20/18 you will need to attend the July 2018 epic training class.

Prospective student signature: _____ Date: _____

Mail:
MVHC
Attn: Rick Fulkerson
33 South 5th St.
Zanesville, OH 43701

Email:
rfulkerson@mvhealthcenters.org