ADVANCED PRACTITIONER APPLICATION

Submit Documentation to:
Heather Hernandez, GME Clerkship Coordinator
2501 North Orange Avenue, Suite 235, Mailbox 38,
Orlando, FL 32804
Email: FH.GME.CLERKSHIP@adventhealth.com
Office: 407-303-7327
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SPECIALTY	**NEW** ☐ **RETURNING** ☐
☐ Advanced Registered Nurse Practitioner (ARNP)	☐ Physician Assistant (PA)
☐ Certified Nurse Midwife (CNM)	☐ Certified Registered Nurse Anesthetist (CRNA)
☐ MSN	☐ DNP

APPLICANT INFORMATION			
Last Name	First Name	M.I.	Date
Gender ☐ Male ☐ Female		Date of Birth	SS#
License Number (if applicable)		E-mail Address	
Home Phone		Mobile Phone	
Emergency Contact Name		Emergency Contact Phone	

SCHOOL CONTACT INFORMATION (OFFICIAL DESIGNATED TO RECEIVE CORESPONDENCE/ EVALUATION)				
School Name		Expected Graduation Date mm/yy		
Coordinator First Name		Coordinator Last Name		
Title		Email		
Street Address	Unit #	City	State	Zip
Business Phone		Business Fax		

TRAINING

AdventHealth Orlando Preceptor (Note: AdventHealth Orlando is unable to assist in finding Preceptors) **REQUEST** (One request per application)			
Last Name	First Name	MI	☐ RN ☐ ARNP ☐ DNP ☐ PA
Specialty/ Department		Start Date	End Date

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 Orlando GME Office. I agree to obtain prior written approval of AdventHealth Orlando before publishing any material related to the learning experience provided.

Applicant Signature	Date

REQUIRED DOCUMENTATION	TO BE SUBMITTED TWO WEEKS PRIOR TO START DATE AFTER APPROVAL
☐ Complete Application with Preceptor Approval Signature	☐ Proof of Malpractice Liability Insurance*
☐ FHESPAA (New applicants only)	☐ Background Security Check* Clear and Valid if completed while enrolled in program
☐ Letter of Good Standing from your School/Program	☐ License (if applicable)
☐ Copy of Photo ID/ Student ID	☐ Respiratory Mask Fit Certificate*, ** (within 12 months)
☐ Proof of Personal Health Insurance* or copy of card	☐ Tuberculosis Screening (PPD)*, ** (within 12 months)
☐ 5- Panel Drug Screen (Amphetamines, Marijuana, Cocaine, Opiates, and Phencyclidine)* Negative and Valid if completed while enrolled in program	
☐ PROOF OF IMMUNIZATIONS* - MMR Vaccination- Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier). Flu shot required if rotating in the months of December- March (If refused must wear mask in all patient care areas).	
***THIS DOCUMENT CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION ****THIS DOCUMENTATION IS AN ANNUAL REQUIREMENT**	

AdventHealth Orlando PRECEPTOR INFORMATION					
I am a Licensed Physician with an unrestricted license to practice in my specialty. I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000. By my signature below, I agree to precept the Student in a clinical rotation. I agree to allow the Student to complete the rotation dates requested on this application. I assume full responsibility for the education, evaluation, conduct and actions of the student while on rotation.					
Physician Last Name	First Name		M.I.	☐ MD ☐ DO ☐ DPM ☐ PhD	
Street Address	Unit #	City	State	Zip	
Business Phone	Business Fax	Email			

DATES APPROVED	
Start Date	End Date
Signature, Practitioner	Date
Signature, Supervising Physician	Date

ADVANCED PRACTITIONER APPLICATION STATUS (FOR GME ADMINISTRATION USE ONLY)		
The Applicant is:	☐ Approved	☐ Declined
☐ Required Documents on File	☐ GME Orientation Date	