**North Carolina Department of Health and Human Services**

**APPLICATION FOR PHN ENROLLMENT
IN THE ENHANCED ROLE NURSE TRAINING PROGRAM**

**Child Health Training Program**

**Instructions**

Complete this application and print it, then sign and date it. Have your supervisor complete the section on page 3 and sign. Scan the approved application and **email it to your Regional Child Health Nurse Consultant**. Faxed applications will not be accepted.

|  |  |
| --- | --- |
| Name: | Click here to enter text. |
| Agency: | Click here to enter text. |
| Business Address: | Click here to enter text.Click here to enter text. |
| Email Address: | Click here to enter text. |

***Must have 6 months experience in ambulatory pediatrics*:**

Type of Employment: [ ] Full Time [ ] Part Time [ ] Contract Service

|  |
| --- |
| **Public Health Nursing Experience** (indicate all that apply) |
| **Clinic** | **Dates (from/to)** |
| Generalized | Click here to enter text. |
| School Health | Click here to enter text. |
| Child Health | Click here to enter text. |
| Other, specify: | Click here to enter text. |

|  |
| --- |
| **Nursing Education** |
|  | **Degree** | **Date Issued** |
| Diploma: | Click here to enter text. | Click here to enter text. |
| Associate Degree: | Click here to enter text. | Click here to enter text. |
| Baccalaureate: | Click here to enter text. | Click here to enter text. |
| Master's: | Click here to enter text. | Click here to enter text. |
| Doctorate: | Click here to enter text. | Click here to enter text. |
| Other: | Click here to enter text. | Click here to enter text. |

**Introduction to Principles and Practices of Public Health Nursing**

Date completed or expected date of completion: Click here to enter text.

**Certifications:** Click here to enter text.

**Primary Clinical Preceptor**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Preceptor 1** |  | **Preceptor 2 (if applicable)** |
| Name | Click here to enter text. |  | Click here to enter text. |
| Address | Click here to enter text. |  | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
| Phone | Click here to enter text. |  | Click here to enter text. |
| E-mail | Click here to enter text. |  | Click here to enter text. |

**Clinical Preceptor Qualifications**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Preceptor 1** |  | **Preceptor 2 (if applicable)** |
| RN who has completed course\* | Click here to enter text. |  | Click here to enter text. |
| Nurse Practitioner (specify type) | Click here to enter text. |  | Click here to enter text. |
| Physician Assistant (specialty) | Click here to enter text. |  | Click here to enter text. |
| MD (specialty) | Click here to enter text. |  | Click here to enter text. |

\*Subject to approval of qualifications, requires a minimum of 12 months of ambulatory pediatric experience.

**Nursing Director/Clinical Supervisor Information**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Nursing Director** |  | **Clinical Supervisor** |
| Name | Click here to enter text. |  | Click here to enter text. |
| Address | Click here to enter text. |  | Click here to enter text. |
|  | Click here to enter text. |  | Click here to enter text. |
| Phone | Click here to enter text. |  | Click here to enter text. |
| E-mail | Click here to enter text. |  | Click here to enter text. |

**Physician Who Will Provide Standing Orders (if applicable)**

|  |  |
| --- | --- |
| Name | Click here to enter text. |
| Address | Click here to enter text. |
| Phone | Click here to enter text. |

**To be Completed by Nurse Supervisor**

Please describe your agency plan for the utilization and support of this enhanced role nurse:

Click here to enter text.

**Signatures**

Student Date

**Supervisor's Approval:** By signing, I certify that I understand that our agency may have to adjust this student's workload to accommodate course requirements.

Supervisor Date