| MSN Practicum application |
| --- |
| Current Employee Information |
| Full Name: | 1st RN Licensure Date: |
| SBL Department: | SBL Date of Hire: | SBL Department Start Date: |
| Current address: |
| City: | State: | ZIP Code: |
| Telephone: | Email Address: | Credentials: |
| If not employed at SBL, where are you employed? |
| Program Information |
| University: | Major: |
| Start Date: | Graduation Date: | Current GPA: |
| Clinical Requirements |
| Clinical Course: | Dates of Course: | Hours Required: |
| Clinical Requirement: |
| Desired Department: | Desired Preceptor: |
| Scheduling Needs: | Projects: |
| Clinical requirements |
| Clinical Course: | Dates of Course: | Hours Required: |
| Clinical Requirement: |
| Desired Department: | Desired Preceptor: |
| Scheduling Needs: | Projects: |
| Clinical requirements |
| Clinical Course: | Dates of Course: | Hours Required: |
| Clinical Requirement: |
| Desired Department: | Desired Preceptor |
| Scheduling Needs: | Projects |
| Clinical requirements |
| Clinical Course: | Dates of Course: | Hours Required: |
| Clinical Requirement: |
| Desired Department: | Desired Preceptor: |
| Scheduling Needs: | Projects: |
| Clinical requirements |
| Clinical Course: | Dates of Course: | Hours Required: |
| Clinical Requirement: |
| Desired Department: | Desired Preceptor: |
| Scheduling Needs: | Projects: |
| **CURRENT POSITION** |
| Title: | Department: | Start Date: |
| Supervisor: | Contact Email: |
| Job Duties: |
| **PREVIOUS POSITIONS** |
| Title: | Department: | Employment Dates: |
| Supervisor: | Contact Email: |
| Job Duties: |
| Title: | Department: | Employment Dates: |
| Supervisor | Contact Email |
| Job Duties: |
| Title: | Department: | Employment Dates: |
| Supervisor: | Contact Email: |
| Job Duties: |
| Signatures |
| I authorize the verification of the information provided on this form as to my enrollment and employment. I have retained a copy of this application. |
| Signature of applicant: | Date: |

**Instructions: For all information in Clinical Requirements Sections, copy information directly from course information. Do not summarize or restate requirements.**

**All Dates of Course must be specific month/date/year. If you do not have this information, obtain it from your Program Advisor. Do not submit the form without the exact dates completed for all clinical requirements.**

**The Hours Required must be specific in each Clinical Requirement. This includes any hours that will be required in a specialty area.**

**Incomplete applications will not be returned to the applicant and will not be reviewed until they are completed as instructed.**

***All applicants must submit a copy of their current transcriptions with their application to:***

***Tracey McCord, MSN, BA, RN, NPD-BC, Professional Development Coordinator***

TMcCord@sblhs.org

217-238-4987