



**Submit Documentation to:**

Heather Hernandez, GME Clerkship Coordinator  
 2501 North Orange Avenue, Suite 235, Mailbox 38,  
 Orlando, FL 32804  
 Email: FH.GME.CLERKSHIP@flhosp.org  
 Office: 407-303-7327  
 Fax: 407-303-7323

**ADVANCED PRACTITIONER APPLICATION**

<b>SPECIALTY</b>		<b>NEW</b> <input type="checkbox"/>	<b>RETURNING</b> <input type="checkbox"/>
<input type="checkbox"/> Advanced Registered Nurse Practitioner (ARNP)	<input type="checkbox"/> Physician Assistant (PA)		
<input type="checkbox"/> Certified Nurse Midwife (CNM)	<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)		
<input type="checkbox"/> MSN	<input type="checkbox"/> DNP		

<b>APPLICANT INFORMATION</b>					
Last Name		First Name		M.I.	Date
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	SS#	
License Number (if applicable)			E-mail Address		
Home Phone			Mobile Phone		
Emergency Contact Name			Emergency Contact Phone		

<b>SCHOOL CONTACT INFORMATION</b> (OFFICIAL DESIGNATED TO RECEIVE CORRESPONDENCE/ 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		

**Florida Hospital Preceptor** (Note: Florida Hospital is unable to assist in finding Preceptors)

**TRAINING REQUEST** (One request per application)

Last Name	First Name	MI	<input type="checkbox"/> RN <input type="checkbox"/> ARNP <input type="checkbox"/> DNP <input type="checkbox"/> 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 Florida Hospital GME Office. I agree to obtain prior written approval of Florida Hospital before publishing any material related to the learning experience provided.

Applicant Signature	Date
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REQUIRED DOCUMENTATION		TO BE SUBMITTED TWO WEEKS PRIOR TO START DATE AFTER APPROVAL	
<input type="checkbox"/> Complete Application with Preceptor Approval Signature		<input type="checkbox"/> Proof of Malpractice Liability Insurance*	
<input type="checkbox"/> FHESPAA (New applicants only)		<input type="checkbox"/> Background Security Check* <small>Clear and Valid if completed while enrolled in program</small>	
<input type="checkbox"/> Letter of Good Standing from your School/Program		<input type="checkbox"/> License (if applicable)	
<input type="checkbox"/> Copy of Photo ID/ Student ID		<input type="checkbox"/> Respiratory Mask Fit Certificate* , ** (within 12 months)	
<input type="checkbox"/> Proof of Personal Health Insurance* or copy of card		<input type="checkbox"/> Tuberculosis Screening (PPD)* , ** (within 12 months)	
<input type="checkbox"/> 5- Panel Drug Screen (Amphetamines, Marijuana, Cocaine, Opiates, and Phencyclidine)* Negative and Valid if completed while enrolled in program			
<input type="checkbox"/> 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			

FLORIDA HOSPITAL PRECEPTOR INFORMATION					
<p>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.</p>					
Physician Last Name		First Name		M.I.	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> 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:		<input type="checkbox"/> Approved		<input type="checkbox"/> Declined	
<input type="checkbox"/> Required Documents on File			<input type="checkbox"/> GME Orientation Date		