NMC health

APPLICATION FOR CAPSTONE / OBSERVATION / STUDENT PRACTICUM

Please complete application. Return all paperwork to the Nursing Administration Office or Education Coordinator for processing.

Mailing Address: 600 Medical Center Drive, PO Box 308, Newton, KS 67114

robyn.davis@mynmchealth.org
Ph: 316-804-6005
Fax: 316-804-6260

jennifer.fernandez@mynmchealth.org
Ph: 316-283-2700, ext. #3710
Fax: 316-804-6268

PRIVILEGES REQUESTED

☐ BSN ☐ BSN to MSN ☐ CNA ☐ Observer ☐ Other_____ ☐ RN ☐ RN to BSN ☐ Surgical Tech

APPLICANT: Please complete information below and provide copy of current license, if applicable.

Type of Program: _____

License #: _____ Expiration Date: _____ ☐ N/A

PERSONAL IDENTIFICATION INFORMATION

Applicant (first, middle, last): _____ Date of Birth: _____

Home Address (street, city, state, zip): _____

Home Phone: _____ Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

SCHOOL/PROGRAM INFORMATION

School Affiliation: _____

Address (street, city, state, zip): _____

Program Contact: _____ Phone: _____

Date of Program Completion: _____

Supervising/Practicum Coordinator: _____

Rotation Dates Requested: From: _____/_____/_____ To: _____/_____/_____

Estimated Total # of Rotation Hours: # _____ hours

CLINICAL PRACTICUM REQUIREMENTS

Documentation of the following must be submitted with your application–NMC may administer Flu and TB if incomplete:

- ☐ Clinical CPR certification, if applicable
- ☐ Criminal background check on file at affiliated program or place of employment, if applicable
- ☐ Health insurance, if applicable
- ☐ Influenza Vaccine (*documentation required per hospital specific dates*)
- ☐ Liability insurance, if applicable
- ☐ TB skin test
- ☐ COVID-19 Vaccination/Exemption Status

By signing below I attest that I have had the following immunizations:

- ☐ MMR Immunization or Titer
- ☐ Series of 3 Hepatitis B Vaccines or Titer
- ☐ Td/tdap Booster within the Last 10 Years
- ☐ Varicella Vaccine (or a Positive History of Chickenpox) or Titer

Signature: _____ Date: _____

OFFICE USE ONLY										
Badge with computer access	☐Yes	☐No	☐N/A	Date _____/Int___	ID verified, if applicable	☐Yes	☐No	☐N/A	Date _____/Int___
Badge issued	☐Yes	☐No	☐N/A	Date _____/Int___	License verified, if applicable	☐Yes	☐No	☐N/A	Date _____/Int___
Badge returned	☐Yes	☐No	☐N/A	Date _____/Int___	IS registration complete	☐Yes	☐No	☐N/A	Date _____/Int___
Community benefit hrs recorded	☐Yes	☐No	☐N/A	Date _____/Int___	Photo consent, if applicable	☐Yes	☐No	☐N/A	Date _____/Int___
Confidentiality statement	☐Yes	☐No	☐N/A	Date _____/Int___	Process complete/filed	☐Yes	☐No	☐N/A	Date _____/Int___

NOTE: _____

_____