Application for Advanced Practice Provider Clinical Rotation and Graduate or Post Graduate Nursing Practicum Experience

Submit to: APPstudents@ochsner.org
1401-A Jefferson Highway, New Orleans, LA 70121

To Be Completed By The Applicant

Applicant's Name: ____
Last First MI

Mailing Address: ____
Street Address City State Zip Code

Telephone Number: ( ) ____________________ School E-mail Address: ____________________

University ID Number ____________________ Last 4 Social Security Number: ____________________

Date of Birth: ____________________ Attended Previous Ochsner Facility Yes No

Have you ever worked at Ochsner? ☐ YES ☐ NO ☐ Current employee Previous ADID ____________________
If yes, please explain reason for leaving/termination: ____________________

Education Information

University/College: ____________________ Expected Graduation Date: ____________________

Number of hours for rotation: ____________________ Instructor's Name: ____________________

LA or MS Nursing License #: ____________________ BLS Expiration Date: ____________________

Clinical Area Desired

____ __________ to __________
Clinical Area/Department (please indicate hospital or clinic) mm/dd/yyyy mm/dd/yyyy

Select Location/Region: New Orleans St. Bernard Baton Rouge Mississippi
River Parishes North Shore Bayou West Bank

I agree that all information provided on this application is true and accurate.

Applicant's Signature: ____________________ **Date:** ____________________

To Be Completed By The Preceptor

I agree to precept the above captioned student and understand the guidelines and limitations for the visiting student and will ensure compliance.

____________________ ____________________
Preceptor Name Preceptor Signature

____
Date

To Be Completed By Ochsner's Academics Department

Date Submitted: ____________________ Date Application Materials Completed: ____________________

Notes: ____