

North Carolina Department of Health and Human Services

APPLICATION FOR PHN ENROLLMENT IN THE ENHANCED NURSE TRAINING PROGRAM

Please print this application and submit a separate copy for each course in the Enhanced Nurse Training Program that you wish to attend.

Name: _____ Social Security Number: _____

Agency: _____

Business Address: _____

Date of Employment: _____

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

PLEASE INDICATE THE COURSE FOR WHICH YOU ARE APPLYING:

PHN NURSING EXPERIENCE (indicate all that apply)

Table with 4 columns: Clinic, Dates (from/to), Clinic, Dates (from/to). Rows include Generalized, STD, HIV Early Intervention, HIV Counseling & Testing, Home Health, Maternity, Family Planning, Child Health, Adult Health, T.B., School Health, and Other (specify).

NURSING EDUCATION

Table with 2 columns: Degree, Date Issued. Rows include Diploma, Associate Degree, Baccalaureate, Master's, Doctorate, Other, and (NP, PA, etc.).

INDICATE YOUR APPROPRIATE CLASSIFICATION

- [] Registered Nurse (staff nurse--clinic nurse)
[] Nursing Supervisor: [] I [] II
[] Public Health Nurse: [] I [] II [] III
[] Nursing Director: [] I [] II [] III
[] Nurse Practitioner I: Specialty: _____
[] Nurse Practitioner II: Specialty: _____
[] Certified RN Midwife: [] I [] II [] III

COURSES COMPLETED AND/OR IN PROGRESS

	<u>Date Completed</u>	<u>Expected Date of Practicum Completion</u>
Introduction to Principles and Practices of PH Nursing	_____	_____
Child Health Training Program	_____	_____
Physical Assessment of Adults	_____	_____
CDC STD Clinician Training	_____	_____
PHN Supervisor Course	_____	_____
HIV Prevention Counseling and Testing	_____	_____
Women's Health Core Course	_____	_____
Maternal Health Training Program	_____	_____
Other (identify specialty, i.e. any training that meets Category II)	_____	_____

CERTIFICATIONS:

American Nurses Credentialing Center Other: _____

If you have completed Physical Assessment of Adults, are you currently practicing those skills in a clinic setting? Yes No

CLINICAL ADVISOR INFORMATION

Name (Advisor 1): _____	(Advisor 2, if applicable): _____
Address _____	Address _____
_____	_____
Phone: _____	Phone: _____
Fax: _____	Fax: _____
E-mail _____	E-mail _____

CLINICAL ADVISOR QUALIFICATIONS:

Advisor 1:	Advisor 2:
<input type="checkbox"/> RN who has completed course*	<input type="checkbox"/> RN who has completed course*
<input type="checkbox"/> Nurse Practitioner (type: _____)	<input type="checkbox"/> Nurse Practitioner (type: _____)
<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> MD	<input type="checkbox"/> MD

*Subject to approval of qualifications

PHYSICIAN WHO WILL PROVIDE STANDING ORDERS (if applicable):

Name: _____

Address: _____

_____ Phone: _____

TO BE COMPLETED BY NURSE SUPERVISOR:

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

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 _____

Please print and complete this form and send it to:
Tavie Flanagan, Continuing Education Specialist
Office of Continuing Education
Campus Box 8165
UNC-CH School of Public Health
Chapel Hill, NC 27599-8165
(NC State Courier Code 17-61-04)