

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: _____

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 2 columns of clinic types and their corresponding dates (from/to). Includes categories like Generalized, STD, HIV Early Intervention, etc.

NURSING EDUCATION

Table for nursing education with columns for Degree and Date Issued. Includes options for Diploma, Associate Degree, Baccalaureate, Master's, Doctorate, and Other.

INDICATE YOUR APPROPRIATE CLASSIFICATION

- List of classification options with checkboxes and radio buttons, including Registered Nurse, Nursing Supervisor, Public Health Nurse, Nursing Director, Nurse Practitioner I/II, and Certified RN Midwife.

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)