| MSN Practicum application | | | | |
| --- | --- | --- | --- | --- |
| Current Employee Information | | | | |
| Full Name: | | | | 1st RN Licensure Date: |
| SBL Department: | | SBL Date of Hire: | | SBL Department Start Date: |
| Current address: | | | | |
| City: | | State: | | ZIP Code: |
| Telephone: | | Email Address: | | Credentials: |
| If not employed at SBL, where are you employed? | | | | |
| Program Information | | | | |
| University: | | | Major: | |
| Start Date: | | Graduation Date: | | Current GPA: |
| Clinical Requirements | | | | |
| Clinical Course: | Dates of Course: | | | Hours Required: |
| Clinical Requirement: | | | | |
| Desired Department: | | | | Desired Preceptor: |
| Scheduling Needs: | | | Projects: | |
| Clinical requirements | | | | |
| Clinical Course: | Dates of Course: | | | Hours Required: |
| Clinical Requirement: | | | | |
| Desired Department: | | | | Desired Preceptor: |
| Scheduling Needs: | | | Projects: | |
| Clinical requirements | | | | |
| Clinical Course: | Dates of Course: | | | Hours Required: |
| Clinical Requirement: | | | | |
| Desired Department: | | | | Desired Preceptor |
| Scheduling Needs: | | | Projects | |
| Clinical requirements | | | | |
| Clinical Course: | | Dates of Course: | | Hours Required: |
| Clinical Requirement: | | | | |
| Desired Department: | | | | Desired Preceptor: |
| Scheduling Needs: | | | Projects: | |
| Clinical requirements | | | | |
| Clinical Course: | Dates of Course: | | | Hours Required: |
| Clinical Requirement: | | | | |
| Desired Department: | | | | Desired Preceptor: |
| Scheduling Needs: | | | Projects: | |
| **CURRENT POSITION** | | | | |
| Title: | Department: | | | Start Date: |
| Supervisor: | | | Contact Email: | |
| Job Duties: | | | | |
| **PREVIOUS POSITIONS** | | | | |
| Title: | Department: | | | Employment Dates: |
| Supervisor: | | | Contact Email: | |
| Job Duties: | | | | |
| Title: | Department: | | | Employment Dates: |
| Supervisor | | | Contact Email | |
| Job Duties: | | | | |
| Title: | Department: | | | Employment Dates: |
| Supervisor: | | | Contact Email: | |
| Job Duties: | | | | |
| Signatures | | | | |
| I authorize the verification of the information provided on this form as to my enrollment and employment. I have retained a copy of this application. | | | | |
| Signature of applicant: | | | | Date: |

**Instructions: For all information in Clinical Requirements Sections, copy information directly from course information. Do not summarize or restate requirements.**

**All Dates of Course must be specific month/date/year. If you do not have this information, obtain it from your Program Advisor. Do not submit the form without the exact dates completed for all clinical requirements.**

**The Hours Required must be specific in each Clinical Requirement. This includes any hours that will be required in a specialty area.**

**Incomplete applications will not be returned to the applicant and will not be reviewed until they are completed as instructed.**

***All applicants must submit a copy of their current transcriptions with their application to:***

***Tracey McCord, MSN, BA, RN, NPD-BC, Professional Development Coordinator***

[TMcCord@sblhs.org](mailto:TMcCord@sblhs.org)

217-238-4987