# APPLICATION

**Advanced Practice Provider Clinical Rotation or Practicum Experience**
**Graduate/Doctoral Nursing**

Submit to **OLHS.students@ochsnerlsuhs.org** **for Shreveport or OLHS-education@ochsnerlsuhs.org for Monroe.**

APPLICATIONS MUST BE COMPLETED AND SUBMITTED ELECTRONICALLY. HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.

## PERSONAL / EDUCATIONAL INFORMATION

Name: _____
LAST FIRST MI

Mailing Address: _____
CITY STATE ZIP

Phone Number: _____ Student Email Address: _____

School Name: _____ Instructor Name: _____

Program: _____ Anticipated Graduation Date: _____

Have you ever worked at Ochsner? ☐ YES ☐ NO ☐ CURRENT EMPLOYEE

If yes, please explain reason for leaving/termination: _____

## CLINICAL ROTATION INFORMATION

Semester/Quarter: SELECT

Requested Campus/Clinic: SELECT BLS Expiration Date: _____

Requested Unit/Department: _____ LA Nursing License #: _____

**Schedule**

| | Start Time | End Time |
|---|---|---|
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |
| Sunday | | |

Rotation START DATE: _____ Rotation END DATE: _____

Total Number of Day/Hours requested for rotation:

Total: _____ (NUMBER) SELECT (DAYS/HOURS)

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

_____ _____
Applicant 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 COMPLTED BY HOSPITAL CLINICAL COORDINATOR

Date Submitted: _____ Date Application Materials Completed: _____

Notes: _____