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Date Received:

By:

Manual Therapies for the Hospitalized Patient

APPLICATION

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| --- | --- |
| Date: |  |

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| Application for: (Please √ one.) |  | Spring (March class) |  |  | Fall (September class) |

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| First Name: |  | Middle Initial: |  | Last Name: |  |

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| Address: |  |
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| City: |  | State: |  | Zip: |  |

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| --- | --- |
| Email: |  |

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| Phone: |  | ( home or  mobile?) Please identify. |

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| Are you legally authorized to work in the United States? | Yes  No |

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| **Emergency Notification** | | |
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| Name: | | Relation: |
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| Address: | | Phone: |
|  | |  |
| City: | State: | Zip: |

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| **Education** | | | | | | | | |
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| **Colleges/Universities Attended** |  | **City** |  | **State** |  | **Dates Attended** |  | **Degree(s) Earned** |
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| **Employment**  List work experience, beginning with the most recent. | | | | |
| **Dates** | **Employer** | **Position/Type of Work** | **Supervisor and Title** | **Reason for Leaving** |
| From: | Name: |  | Name: |  |
| To: | Address: | Title: |
| From: | Name: |  | Name: |  |
| To: | Address: | Title: |
| From: | Name: |  | Name: |  |
| To: | Address: | Title: |
| From: | Name: |  | Name: |  |
| To: | Address: | Title: |

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| **Professional Certification or License** | |
| **Type** | **Number** |
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Attach:

1. One page personal statement summarizing your reasons for applying and expected educational goals you want to achieve upon completing the program

2. Professional resume or curriculum vitae

3. A description of any special needs (e.g., health, financial, transportation etc.)

4. A copy of your State of Ohio Nursing Board License from the following website – <https://license.ohio.gov/lookup/default.asp>

5. A copy of your health insurance coverage certificate

6. Student Health Requirements as noted below. Mandatory for all applicants, including Cleveland Clinic employees

* 1. TB (2-step Mantoux) or QuantiFERON TB Gold, within the last 6 months

**Non-Cleveland Clinic employees can get TB testing done at these sites:**

Company Health Care at Marymount Hospital

Southside Corporate Centre

5595 Transportation Blvd., Suite 220

Garfield Heights, Ohio 44125

Phone: 216.587.5431 | Fax: 216.587.5474

Company Health Care at Medina Hospital

1000 East Washington St. Main Entrance, 1st Floor

Medina, Ohio 44256

Phone: 330.721.4955 | Fax: 330.721.4907

Testing is available 7:30 am to 4 pm, Monday through Friday. The fee is $27. Cash or MasterCard/Visa is accepted at the time of testing.

Please note that TB Skin Testing requires an injection and a follow-up read in 48 to 72 hours. Plan for both visits or the test will need to be repeated.

* 1. MMR Mumps, Rubella, Rubeola Immunity (Titers). If not immune, vaccine (booster) required
  2. Varicella (Chicken Pox) Immunity (Titer). If not immune, vaccine (booster) required
  3. Tdap (Tetanus, Diphtheria, Pertussis) booster within the last 10 years
  4. Hepatitis B Immunity (Titer) or Waiver, assuming risk of exposure
  5. Flu shot or medical/religious waiver form (during flu season – November through March)

**Cleveland Clinic Employees**:

Check Ready Set or if titers were drawn before Ready Set was initiated, call Niva Edmondson in Occupational Health at 216.444.6129 to assess if your titers and immunizations are in the system. If not, you will have to have titers drawn in Occupational Health or receive the appropriate boosters.

7. American Heart Association – BLS Healthcare Provider Course

8. Completed Background Release Form

9. Application fee of $10. PLEASE MAKE CHECK PAYABLE TO: CLEVELAND CLINIC SPIRITUAL CARE DEPARTMENT

Send by mail or email as an attachment to:

Karen Fink, Program Director

Manual Therapies for the Hospitalized Patient

Cleveland Clinic

9500 Euclid Avenue/Q1-3

Cleveland, OH 44195

Office: 216.445.9543

Email: [finkk@ccf.org](mailto:finkk@ccf.org)

*Cleveland Clinic does not discriminate in admission, employment, or administration of its programs or activities, on the basis of age, gender, race, national origin, religion, creed, color, marital status, physical or mental disability, pregnancy, sexual orientation, gender identity or expression, genetic information, ethnicity, ancestry, veteran status, or any other characteristic protected by federal, state or local law. In addition, Cleveland Clinic administers all programs and services without regard to disability, and provides reasonable accommodations for otherwise qualified disabled individuals.*

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| **Applicant Reference Form** |
| **Healing Services Manual Therapies for the Hospitalized Patient** |

**To the applicant:** Please complete the following:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | Date of Graduation: |  |
|  | (Last, First, Middle or Maiden Name) |  |  |

**The applicant should sign and date one of the following statements:**

1) I wish to have access to this letter and I understand that under the Family Education Rights to Privacy Act of 1974, 20 U.S.C.A. Par. 1323 g (a) (1) and P.L. 397 of 1978, I have the right to read this recommendation.

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| **Applicant's Signature:** |  | **Date:** |  |

2) I wish this letter to be confidential and I hereby waive any and all access rights granted me by the above laws to this recommendation.

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| **Applicant's Signature:** |  | **Date:** |  |

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| **Applicant Reference Form** | |
| **Healing Services Manual Therapies for the Hospitalized Patient** | |
|  | |
| **Instructions:** | |
| The individual identified below is applying for Cleveland Clinic’s Manual Therapies for the Hospitalized Patient (MTHP) Program. The MTHP Program offers an intense educational experience in Holistic Therapeutic Manual Therapies that comprises didactic, theory-based, laboratory and clinical elements in a complex medical setting. It requires readiness to learn and assimilate a vast amount of medical, laboratory and pharmacological information, along with developmental, social and family history, and then assess how this information impacts the care provided to patients. It also requires a willingness to adapt and modify the current model of care an RN uses to provide safe, effective palliative care. This experience will challenge their practice and belief systems, and require flexibility and acceptance of feedback. Your recommendation is important to our admission process. | |
|  | |
| **Applicant Name:** |  |
| **Address:** |  |
| **City/State/Zip:** |  |

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| Relationship to the applicant (e.g. program director, clinical instructor, biology instructor, academic advisor, etc.): |  |
| How long have you known the applicant? |  |
| What are the outstanding characteristics of the applicant in performance of manual therapies, interpersonal and professional relations, and personal character? | |
| What are the applicant’s strengths? | |
| Which areas require further development? | |
| Would you hire this person to provide holistic manual therapies in your practice? | |

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|  | | 5  Highly recommend | 4 | 3  Neutral | 2 | 1  Would not recommend | Unable to answer |
| Your recommendation of the applicant for the MTHP Program. | |  |  |  |  |  |  |
| Comments: |  | | | | | | |

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| --- | --- | --- | --- | --- | --- |
| Your Name/Title: |  | | | | |
| Place of Employment: |  | | | | |
| Phone Number: |  | Email Address: |  | | |
| Signature: |  | | | Date: |  |

Return Completed Waiver and Recommendation Forms directly to:

|  |  |
| --- | --- |
| Karen Fink, Program Director  Manual Therapies for the Hospitalized Patient  Cleveland Clinic  9500 Euclid Avenue/Q1-3  Cleveland, OH 44195 | Office: 216.445.9543  Fax Number: 216 445-9678  Email: [finkk@ccf.org](mailto:finkk@ccf.org) |

Thank you for your assessment.