Akron General Medical Center Advanced Practice Nursing Department

Please fill out completely and email to APNClinicals@akrongeneral.org

Student Name:_____
(Last) (First) (MI)

Address:_____

Phone #:_____ E-mail_____

Ohio RN License No:_____ Expiration Date:_____

School:_____ Faculty Contact:_____

APN Program:_____ Clinical Specialty:_____
(CNS, CNM, CNP)

Clinical Course Name and Number:_____

Hours Needed:_____

Do you have an ANP/MD or PA who has agreed to precept you at Akron General? ____ Yes ____ No

If yes, _____
Name Location and email

I certify that all information included in this application is true and correct.

_____ _____
Student Signature (Electronic Signature Accepted) Date

Part II: To be completed by Faculty at School of Nursing:

The above named student is in good standing enrolled in

_____ at _____
Clinical Program School

The school has validated that the student has the following:

- A negative PPD by Mantoux method, dated no more than 12 months prior to start date of clinical placement. If PPD was positive, a chest X-ray was obtained and was negative.
- Received the Hepatitis B series of immunizations or signed a waiver of liability if the student refused the vaccination.
- Completed Blood Bourne Pathogen Training within the last calendar year.
- Maintains malpractice insurance in the amount of $1,000,000/$3,000,000 through the school.
- Student has a clean background check in the last 12 months prior to the start of clinical placement.
- This student is authorized to participate in this clinical experience.

_____ _____

Faculty or Representative Electronic Signature Date

_____ _____

Faculty or Representative Name Title

Email Address:_____ Phone:_____