Nurse Practitioner
Fellowship Program

Application

Please check one:

- ☐ **Primary Care NP Fellowship Program**
- ☐ **Psychiatric NP Fellowship Program**

Provider Name____
Last First Middle Degree

Other Name Used____

Address____
Street Apt# City State Zip

Telephone Number____

Date of Birth____

Place of Birth____

Email Address____

Social Security Number__________________________________

Citizenship____
(if other than US provide documentation)

Languages Spoken (please indicate fluency or conversational)

____

1. **Federal DEA** *If you have not graduated, put N/A

   #__________________Expires__________________
   Schedules: ____________________

Community Healthcare Network

2. **National Provider Identifier** *If you have not graduated, put N/A

(NPI)____
NPI Login_________________________
NPI Password______________________

3. **Board Certification** *If you have not obtained, put N/A

Certifying Board___________________ Certificate#________________________
Year Certified______________________ Expires___________________________

If not certified have you been accepted by the board to take the examination and are you actively in the board certification process? Yes____ No____
If yes, indicate planned examination date ______________________

Have you ever taken and failed a certification examination? Yes____ No____
If yes, please explain ____
____

4. **Any other certifications or memberships?**

____
____
____
____
____

5. **Academic Appointments (example: Professor at University)**

Name______________________________ Rank______________________________
Department__________________________
Dates From (mm/yr)_______to _________

Name______________________________ Rank______________________________
Department__________________________
Dates From (mm/yr)_______to _________

Application

Name______________________________ Rank_____________________________
Department__________________________
Dates From (mm/yr)_______to _________

6. **Previous Clinical Rotations**

Institution ________________________________
Dates (mm/yr) _________________
Address____
Specialty____________________________ Preceptor__________________________
Preceptor telephone/email _____________________________________

Institution ________________________________
Dates (mm/yr) _________________
Address____
Specialty____________________________ Preceptor__________________________
Preceptor telephone/email _____________________________________

Institution ________________________________
Dates (mm/yr) _________________
Address____
Specialty____________________________ Preceptor__________________________
Preceptor telephone/email _____________________________________

Institution ________________________________
Dates (mm/yr) _________________
Address____
Specialty____________________________ Preceptor__________________________
Preceptor telephone/email _____________________________________

Institution ________________________________
Dates (mm/yr) _________________
Address____
Specialty____________________________ Preceptor__________________________
Preceptor telephone/email _____________________________________

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7. **Practicing Specialty** (either formal certification or significant practice experience)

   Primary_______________________________ Secondary ___________________________

Essay Questions

Please choose three of the five questions below to respond to. Answer in no more than 2 pages total, singe spaced and in 12 point font.

1. If you were the Dean of your nursing school, what specific three changes would you make, and why? What three attributes of your program would you absolutely keep, and why?

2. "*Learning is not attained by chance, it must be sought for with ardor and attended to with diligence*."— Abigail Adams.
   Explain what you think the above statement means and how this applies to you.

3. Why do you think you will be an asset to Community Healthcare Network's NP Fellowship?

4. What do you consider to be the single most important societal problem pertaining to community healthcare? Why?

5. Briefly describe your short-term and long-term professional goals. Where do you see yourself in 10 years?

Payment

Please submit $50.00 payment, choose one option:

Application

1. **via PayPal** (please put NP Fellowship in the notes) to: event@chnnyc.org

2. **Mailing a check**, payable to Community Healthcare Network to this address:

   ATTENTION:
   CHN Nurse Practitioner Fellowship Program
   c/o Grace O'Shaughnessy
   60 Madison Ave, 5th Floor
   New York, NY 10010

Applicants will not be processed until the application fee is received. Fee can be included in your application packet or sent separately.

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Final Checklist

- ☐ Fellowship Application
- ☐ CHN Application
- ☐ CV in month/year format
- ☐ 3 professional letters of recommendation if not board certified, 2 if board certified:
    - Dated, signed and addressed to Dr. Matthew Weissman, Chief Medical Officer (can be included in packet or sent separately)
    - 1 letter should be from a nursing education program, 1 letter from employment and 1 of your choosing.
    - If more than 5 years post-graduation, 1 letter can be from your current supervisor (in lieu of education program), and 1 from your general employment.
- ☐ Essay Responses (2 pages, total. Not per question)
- ☐ Copy of Diploma (BSN, MSN) **If not obtained, please submit transcripts
- ☐ Copy of License as Nurse Practitioner **Please put N/A if not graduated
- ☐ Copy of License as Registered Nurse
- ☐ Federal DEA license **Please put N/A if not graduated
- ☐ National Provider Identifier **Please put N/A if not graduated
- ☐ ANCC/AANP certification (or evidence of eligibility) **Please put N/A if not graduated
- ☐ Infection Control Certificate
    - (http://www.op.nysed.gov/training/icproviders.htm)
- ☐ 2 passport photos
- ☐ Copy of state issued photo ID
- ☐ $50 application fee
    - Can be submitted by check, payable to Community Healthcare Network OR
    - Can be submitted by PayPal to: event@chnnyc.org (put NP Fellowship in the notes)

Submit application and all materials to:

Community Healthcare Network

Application

NPFellowship@chnnyc.org

Or mail to:

ATTENTION: CHN Nurse Practitioner Fellowship Program
c/o Grace O'Shaughnessy
60 Madison Ave, 5th Floor
New York, NY 10010

Community Healthcare Network

Employment Application

Community Healthcare Network

60 Madison Avenue, New York, NY 10010
Telephone: (212) 545-2400
Fax: (212) 807-0250

It is the policy of Community Healthcare Network ("CHN") to provide equal employment opportunity and to treat all qualified employees and qualified applicants for employment without unlawful discrimination as to race, creed, color, national origin, ancestry, sex, age, disability or handicap, marital status, familial status, gender identity, sexual orientation, alien or citizenship status, veteran status, arrest or conviction record status as a victim of domestic violence, stalking and sex offenses, unemployment status or any other characteristic protected by Federal, State or Municipal Law. This policy applies to all terms and conditions of employment, including, but not limited to recruitment, hiring, placement, promotion, compensation, training, leave of absence, upgrading, demotion, downgrading, transfer, lay-off, termination, and all other terms, conditions or privileges of employment.

PLEASE COMPLETE ALL ITEMS ON THIS APPLICATION. PRINT IN INK.

Position Desired ______________________
____

Preferred Status
☐ FT ☐ Per Diem
☐ PT ☐ Temporary

If selected, when can you start? ____________
Salary Desired ____________

How did you hear about Community Healthcare Network?
☐ Advertisement ____________ (Publication) ☐ Own Initiative ☐ Employment Agency ____________________ (Agency Name)
☐ Internet ☐ Employee Referral ☐ Other, please explain ____________________

If employee referral please give name(s)____

Are you related through blood or marriage to anyone at the Network?
☐ Yes ☐ No If yes, please give name (s)

PERSONAL DATA

Name Last	First	MI

Address Street	Apt#	City	State	Zip

Cell Phone Number	Home Telephone Number	Business Telephone Number

Personal Email Address	Second Email Address

Are you lawfully authorized to work in the United States? ☐ Yes ☐ No

Furnishing proof of identity and legal authority to work in the United States is a condition of employment.

Have you ever been employed at Community Healthcare Network or its predecessor, CFPC? ☐ Yes ☐ No

If yes, give date(s) / position(s) ____

ONLY answer the following two questions if your position requires driving:

1. Do you have a current valid license to operate your vehicle? ☐ Yes ☐ No
2. In the past five (5) years is there anything in your driving record that would render you to be an unsafe driver? ☐ Yes ☐ No

EMPLOYMENT HISTORY

Provide a complete and accurate record of your employment during the last 15 years, beginning with your most recent position:

(1) Employer's Name and Address	Job Title		☐ PT ☐ FT	From: Mo. Yr.	To: Mo. Yr.
Tel. No (Area Code)			Current/Last Supervisor's Name		
Duties Performed					
May we check this reference? ☐ Yes ☐ No If no, please explain.					
Reason for Leaving					
(2) Employer's Name and Address	Job Title		☐ PT ☐ FT	From: Mo. Yr.	To: Mo. Yr.
Tel. No (Area Code)			Last Supervisor's Name		
Duties Performed					
May we check this reference? ☐ Yes ☐ No If no, please explain.					
Reason for Leaving					
(3) Employer's Name and Address	Job Title		☐ PT ☐ FT	From: Mo. Yr.	To: Mo. Yr.
Tel. No (Area Code)			Last Supervisor's Name		
Duties Performed					
May we check this reference? ☐ Yes ☐ No If no, please explain.					
Reason for Leaving					

If you have had more than 3 employers within the past 15 years, please list on a separate sheet of paper. You may also explain any gaps in employment and include any relevant employment experience prior to the last 15 years.

EDUCATION AND TRAINING

Name and Complete Address of Schools Attended	Type of Degree/Diploma	Major/Minor	Did You Graduate?
High School			☐ Yes ☐ No
College *If more than one, please list on a separate page.*			☐ Yes ☐ No
Graduate			☐ Yes ☐ No
Other Training or Education			☐ Yes ☐ No

PROFESSIONAL LICENSES/CERTIFICATIONS/REGISTRATIONS

Are You Currently ☐ Registered ☐ Licensed ☐ Certified		Eligible for ☐ Registration ☐ Licensure ☐ Certification	
Type ____________	State Issued ____________	License No. ____________	Permit No. ____________
☐ CPR Certificate Date ____________		☐ Other Certificate, specify ____________	

SKILLS

Computer Knowledge ☐ Yes ☐ No Specify ____________________	Knowledge of Electronic Medical Records (EMR) ☐ Yes ☐ No Knowledge of Any Other Medical Data Technology ☐ Yes ☐ No Specify ____________________

PERSONAL REFERENCE

List current and former co-workers, colleagues and/or professional acquaintances **not related** to you (other than those listed previously) who can provide first-hand knowledge of your integrity, qualifications and abilities.

NAME	RELATIONSHIP TO YOU	TITLE	TELEPHONE NO. (Include area code)	EMAIL ADDRESS	YEARS KNOWN

CAREFULLY READ AND INITIAL THESE STATEMENTS PRIOR TO SIGNING BELOW

"I declare, as if under penalty of perjury, that the answers contained in this application and any other materials I have submitted are true and complete to the best of my knowledge. I understand that any materially false or misleading information or omissions, including misstatements made during any interviews, will disqualify me from further consideration for employment, and will be justification for my dismissal from employment, if discovered at a later date."

__________________ **INITIALS**

"I agree to immediately notify CHN if I am charged with or convicted of any crime (other than a minor traffic infraction) after receiving a conditional job offer and, if hired, during the entire period of my employment."

__________________ **INITIALS**

"I have all the licenses and professional certifications listed in the job announcement, job advertisement, job description or that are necessary to perform the job(s) for which I am applying."

__________________ **INITIALS**

"I authorize the investigation of all statements contained in this application, accompanying resume (if any), or statements made during any interviews. I further authorize any person, school, current employer (except as expressly noted), past employer(s), and/or organizations to give CHN or any other entity acting on its behalf any and all information they may have, personal or otherwise about me. I release all such parties from all liability for any damages that may result from the furnishing of such information or opinion to CHN."

__________________ **INITIALS**

"I understand that, if hired, I may not hold other employment or engage in other business activities, or any activity that creates a conflict of interest with my position at CHN unless permission is given in writing by CHN in advance of engaging in said activities or employment. I understand that it is my obligation to obtain advance permission and that failure to do so may be grounds for my dismissal."

__________________ **INITIALS**

"If I become employed, in consideration of my continued employment, I understand that I will be expected to conform to the rules and regulations of CHN. I acknowledge that my employment is considered "at-will" and may be terminated at any time with or without cause, and with or without notice, at the option of myself or CHN. I further understand that only CHN's President has the authority to enter into an employment agreement for a specified period of time, change the "at-will" nature of my employment, or make any promises relating to employment, and that any such agreement must be written and signed by CHN's President in order to be effective."

__________________ **INITIALS**

"If extended an offer of employment, I consent to undergo a mandatory pre-placement health assessment/evaluation by a health professional, including screenings for infectious disease immunity. Due to the nature of the services provided by CHN and its commitment to ensuring the health and safety of its employees and patients, I understand that any employment offer is conditioned upon CHN's satisfactory review of the results of this post-offer examination."

__________________ **INITIALS**

____

Signature　　　　　Print Name　　　　　Date

Explanations/Other Employment History