UPC/OHI PRECEPTOR APPLICATION

Demographics

Full Name: _____ DOB: _____ Date_____

Last *First* *MI*

Address: _____

Street Address *Apartment /unit #*

Cell phone: _____ Email_____

Are you at least 18 years of age or older? YES ☐ NO ☐
Have you ever worked at a Hillcrest Hospital/UPC/OHI? YES ☐ NO ☐ If yes, When_____

Have you ever been found guilty, plead no contest, or had a conviction for any criminal act other than a minor traffic violation? YES ☐ NO ☐

If yes, explain: _____

SSN: _____ (Full number is needed for access purposes)

School Information

Name of the university, program, or technical school you are attending:

_____ _____

Name *Address/Location*

Describe your current educational position:

☐ Medical Assistant Student	☐ Medical Student: Year_____
☐ Nursing Student	☐ APRN Student: Specialty_____
☐ PA Student: Specialty_____	☐ Resident/Fellow: Specialty_____

Program Director/instructor or contact name: _____

Email: _____ Phone Number: _____

Anticipated date of graduation or program completion: _____

Please return completed application to: UPC/OHI Education Department, 1145 S. UTICA AVE., Ste. 807, Tulsa, OK 74104 or Email to Students@Hillcrest.com.

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Clinical Rotation Location Information

Clinic Location_____

Office Manager_____

Supervising Physician or APP (if applicable): _____

Please List the dates and time you plan to be in the clinic:

Monday ___(am,pm) Tuesday___(am,pm) Wednesday___(am,pm) Thursday___(am,pm) Friday___(am,pm)

Dates of your anticipated preceptorship: Start_____ End _____

Epic EHR Experience

Have you had Experience using the Epic EHR? ☐ No ☐ Yes.

If yes, describe your training and whether it was inpatient training, ambulatory training, or both.

Acknowledgment

This is to acknowledge that (Name of school) _____

Maintains current copies of the following documents for the preceptor:

- School attestation of current vaccinations
- Evidence of liability insurance
- Current BLS

Signature:

_____ _____

Clinical Preceptor's Signature *Date*

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For Preceptor Program - internal use only

☐ Approved ☐ Not Approved _____ _____

Reviewers Signature *Date*

Confirmed Start Date: _____ **Conformed End Date:** _____

Additional information: _____

INFORMATION CONFIDENTIALITY AND SECURITY AGREEMENT (ICSA) signed: _____

Clinic Location_____

Office Manager_____

Supervising Physician or APP (if applicable): _____

***MA student's only*:** Program director notified_____(date)

_____

1. Referred to HR for Lawson access: _____ (Not for SCO's)

Date

2. Referred to IT for Epic Access: _____ (Not for SCO's)

Date

3. Application Referred to Clinic Manager: _____

Date

For Human Resources only

Lawson assignment created: _____ Lawson by whom: _____

Date *initial*

IT access requested on: _____ Student Contractor ID#: _____

For IT only

Epic access created: _____ By whom: _____

Date *Initial*

Date Epic training is assigned: _____ Date Epic training completed: _____

Date *Date*

What Epic training module was assigned (describe): _____

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