



Patient Plus Student Program Application

Name _____ Date Of Birth _____
 Last First Middle

Contact # _____ Email _____

Address _____ City/State _____ Zip _____

Emergency Contact Name	Relationship to Applicant	Contact Number

Name of School/Program _____

Program Contact Person _____ Program Phone _____

Anticipated Date of Program Completion _____ Credits Completed _____

How many hours would you like to precept with one of our providers? _____

Desired Schedule:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Tell us why are you interested in precepting/shadowing at Patient Plus.

Tell us about your future career goals.

In addition to this application, please submit the following to Nhonore@patientplusuc.com

- Current Resume
- Immunization Records
- Tuberculin Skin (TB) skin
- Required course documentation/preceptor agreements (if applicable)