



## **NURSE PRACTITIONER POST-GRADUATE RESIDENCY PROGRAM APPLICATION**

*Supported in part by a grant from the Independence Blue Cross Foundation*

---

The mission of Puentes de Salud is two-fold: First, to partner with South Philadelphia's rapidly growing Latino immigrant community to build long-term prosperity by addressing immediate education, health and social service needs. Second, to create a responsible learning environment for future generations of advocates, educators, healthcare providers to examine social determinants of health, social justice and structural violence in practice and to explore their impact on the social determinants of health within a marginalized community.

Puentes de Salud believes that a comprehensive strategy to promote wellness in any community must work towards diminishing the effects of structural violence and social injustice on the communities, specifically access to health care, economic opportunity, and education. Because most of the underlying causes of inequality are social and structural in nature, our actions must be, too. For this reason, we offer integrated social and medical services to support full mental, emotional, and physical well-being from the individual to the community <https://www.facebook.com/BuzzfeedCommunity/videos/1380789082008242/y>. The goal is to provide the social, economic, and health resources necessary for individual and community empowerment. At Puentes de Salud, we are challenging the idea that deep and long-standing inequalities are acceptable realities within our society. We are not only re-imagining but also fostering an environment in which our vision of equitable access to health care, education, and empowerment exists.

The Nurse Practitioner (NP) Post-Graduate Residency Program that Puentes has conceived is based on the following:

- NPs will continue to play a significant role in providing primary care to patients in many different settings, which includes a growing emphasis on community-based settings.
- Medical education and nursing education currently operate independently of one another. Therefore NPs and medical trainees do not have an opportunity to learn to work together as part of an interdisciplinary team, even though optimal patient care requires a highly collaborative approach.
- Educational programs for NPs do not include sufficient exposure to clinical settings. To be effective, it is important for NPs to:
  - (a) Spend time in a health clinic and an emergency department in order to know when a clinic patient should be seen by the emergency department and vice versa and
  - (b) Gain exposure to wide variety of problems, so they know when referral to a specialist is needed (rather than

needing in-depth exposure to the diagnoses or treatment of health issues that specialists address.)

Therefore, Puentes has developed the framework for an NP Post-Graduate Residency Program with three overarching goals:

1. Significantly expand and strengthen the clinical skills of recent NP graduates, with a specific focus on developing the NP's capacity to function independently and collaborate with physicians when necessary.
2. Help to break down silos between the medical education and nursing education worlds, with a specific focus on helping to advance an interdisciplinary model of health care provision.
3. Demonstrate how an NP Post-Graduate Residency Program increases access, improves quality, and decreases cost, with the explicit goals of promoting adoption of such programs as the state of the art and convincing the federal government to establish funding streams for NP post-graduate training as it does for medical residents' education.

#### **APPLICATION REQUIREMENTS CHECKLIST**

- Personal Statement of qualifications, interest and motivation to participate in this program, along with short and long-term career goals & commitment serving underserved population
- Recent Graduate <18 months (Master's or DNP)
- Official graduate school transcripts
- GPA 3.2; TOEFL 109 (within 2yrs)
- Curriculum Vitae - including professional history
- 3 signed letters of recommendations in sealed envelopes (2 clinical, 1 peer reference)
- PA State RN, CRNP licensure
- Copies of license(s) from any other state
- Copy of Driver's License
- If applicable, non US residents must provide a copy of their permanent resident card / VISA / proof of eligibility to work in US
- ANCC/AANP board certification FNP
- Prescriptive authority/board certification to be completed during orientation
- Proof of Spanish proficiency - oral/written preliminary examinations
- Signed statement by a medical licensed independent provider attesting to your overall health status from your last physical - free of communicable diseases, ability to perform your job functions, etc. This statement must be from a physical exam within the last 12 months.

**APPLICATION PERSONAL INFORMATION**

Name: \_\_\_\_\_

First Middle Degree Last

Residence: \_\_\_\_\_

Street apt#/suite#

City State Zip Code

Email address (primary): \_\_\_\_\_

Telephone: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Citizenship (if other than US, provide copy): \_\_\_\_\_

Languages (proficiency): \_\_\_\_\_

Emergency Contact (primary), Relationship: \_\_\_\_\_

Emergency Contact (secondary), Relationship: \_\_\_\_\_

**LICENSURE/REGISTRATIONS**

**Medical:**

List all current, past and type of licenses. Indicate restrictions on any current or prior licensure.

State/Country	Type	Number	Date Issued	Expiration Date	Restrictions

**Federal Controlled Substance Registrations:**

(Circle or list authorized schedules)

Federal DEA Number \_\_\_\_\_ Expires \_\_\_\_\_ Schedules: 2 2N 3 3N 4 5

**State Controlled Substance Registrations: (Circle or list authorized schedules)**

State \_\_\_\_\_ Number \_\_\_\_\_ Expires \_\_\_\_\_ Schedules: 2 2N 3 3N 4 5

State \_\_\_\_\_ Number \_\_\_\_\_ Expires \_\_\_\_\_ Schedules: 2 2N 3 3N 4 5

**National Provider Identifier (NPI):** \_\_\_\_\_

NPI login \_\_\_\_\_ NPI password \_\_\_\_\_

*You may call 1-800-465-3203 to obtain this information if you do not know your login and password. NPI will not release this information to a third party.*

**EDUCATION**

List education in chronological order – include **month/year** of attendance and graduation and **full mailing address** of institution.

Institution	Address	Degree	Dates attended

**ROTATIONS/FELLOWSHIPS/PRECEPTORSHIPS**

If applicable, list in chronological order – include month/year of attendance and full mailing address of institution.

Institution & Address	Certificate	Specialty	Dates	Program Director

**BOARD CERTIFICATION STATUS**

Specialty	Certification Board	Certification Number	Dates

Have you ever taken and failed a certification examination? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, indicate the portion(s) failed and the year. Written \_\_\_\_\_ Oral \_\_\_\_\_

**MEMBERSHIPS & CERTIFICATIONS**

Indicate type or field in which certified (examples BLS, ACLS, ATLS), dates, and organization issuing the certificate. Also include memberships to IPAs, medical societies, AMA, and like clinical organizations)

Certification	Organization	Dates

**CLINICAL REFERENCES (3)**

	Reference #1	Reference #2	Reference #3
<b>NAME</b>			
<b>RELATIONSHIP</b>			
<b>INSTITUTION</b>			
<b>ADDRESS</b>			
<b>TELEPHONE</b>			
<b>EMAIL</b>			

**DISCIPLINARY ACTIONS**

Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, made subject to probationary terms, or not renewed? Or have you relinquished or withdrawn or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional conduct? If yes, please provide a full explanation on a separate sheet.

**STATEMENT OF APPLICATION AND RELEASE FORM (PLEASE READ CAREFULLY BEFORE SIGNING)**

I understand that Puentes de Salud is required to credential providers involved in the NP Residency Program and therefore, I agree to make available to Puentes de Salud any documents or records, either in my possession or in the possession of another, which may have a material and reasonable bearing on my suitability as a contracted provider.

I hereby authorize any and all persons, institutions and organizations, including those specifically identified in this application, with information pertaining to my professional standing or qualifications as a provider to furnish upon request, all such information to Puentes de Salud, its employees and agents. In consideration for the furnishing by a person, institution or organization of information, I release the person, institution, or organization from and against any and all liability, loss, damage, claim or expense of any kind arising from or in connection with, disclosure of information to Puentes de Salud made in good faith and without malice in conformance with this authorization.

I certify that the information provided herein, including attachments, represents full and truthful disclosures of the matters to which they pertain.

A copy of this document shall be considered as valid as the original.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTICE OF BACKGROUND CHECK AND FAIR CREDIT REPORTING ACT DISCLOSURE**

Please send us a copy of your background check. If you do not have one please complete the instructions below. All information given to Puentes is kept strictly confidential and not shared with any third parties. The information is submitted to the Pennsylvania Department of Public Welfare and Pennsylvania Access to Criminal History (PATCH).

Pennsylvania Criminal History (EPATCH)

1. Link: <https://epatch.state.pa.us/Home.jsp>
2. Select "New Record Check (Volunteers only)"
3. Read terms and conditions, select "Accept" and "Continue."
4. Complete form, click "Next."

Volunteer Organization Name: Puentes de Salud

Name: Volunteer's name

Address: Volunteer's home address

Email address: Volunteer's email address

Phone number: Volunteer's phone number

5. Click "Proceed."
6. Volunteer completes form with their personal information. Click "Enter this Request." Then click "Finished."
7. Review that information is correct, then click "Submit."
8. Click blue link "Certification Form" to access results.
9. Click "Save" to download the certificate.
10. Email to [npresidency@puentesdesalud.org](mailto:npresidency@puentesdesalud.org)

**HEALTH STATEMENT FORM**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Date of Exam:** \_\_\_\_\_ (must be within the last 12 months)

Practitioner Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number \_\_\_\_\_

My employer Puentes de Salud requires documentation from my healthcare provider confirming that I am in good health, free of communicable disease and able to perform functions of my job in the capacity of a Nurse Practitioner.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This is to confirm that \_\_\_\_\_ is in good health, free of communicable diseases and able to work with clients.**

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**APPLICANT'S AGREEMENT AND CERTIFICATION**

I certify that the answers given in this application are true to the best of my knowledge.

I understand that the use of this application form does not indicate that there are any positions open and does not in any way obligate Puentes de Salud

I understand that should I be granted an interview, no representations that may be made at the interview are to be construed as creating any obligation, promise or contract on behalf of Puentes de Salud.

I understand that the lack of truthfulness, misleading information or material omissions given in my application, resumes, interview(s) or during the course of my employment are grounds to terminate the hiring process or employment whenever they are discovered.

I understand that acceptance for employment shall depend on satisfactory replies from my references and other background checks.

I have read, understood and agree to the foregoing.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date\_\_\_\_\_

**Applicants are highly encouraged to submit application documents electronically.**

To submit your completed application by email, please use the following address:

[npresidency@puentesdesalud.org](mailto:npresidency@puentesdesalud.org)

Subject: ATTENTION: POST-GRADUATE NP RESIDENCY PROGRAM APPLICATION

To mail your application through certified mail, use the following address:

POST-GRADUATE NP RESIDENCY PROGRAM APPLICATION

Attention: Sharon Katzenbach, MSN, CRNP, Director Nurse Practitioner Residency Program

Puentes de Salud

1740 South Street

Philadelphia, PA 19146

If you have questions, please contact Sharon Katzenbach, MSN, CRNP at 215-459-4799 or e-mail [npresidency@puentesdesalud.org](mailto:npresidency@puentesdesalud.org)