



Clinical Student Application

Area of Focus for Practicum: Family Peds Other: _____

Practicum Start Date: ____/____/____

Hours Needed: _____

Preferred days (please note we may not be able to accommodate your request):

Monday Tuesday Wednesday Thursday Friday No Preference

Applicant Information

Name: _____ Date: ____/____/____

First MI Last

Address: _____

Street Address

Apartment/Unit #

City

State

ZIP Code

Phone: (____) _____ Email: _____

Education and Experience

School Attending: _____ Phone: (____) _____

Expected Graduation Date: ____/____/____ Specialty/Specialties: _____

School Address: _____

Street Address

City

State

ZIP Code

Clinical Professor/Staff Member: _____ Contact Number: (____) _____

School Contact: _____ Contact Number: (____) _____

List any previous clinical references, beginning with most recent.

1. Clinic/Site: _____ Phone: (____) _____

Name of Preceptor: _____ Family Peds Other: _____

Practicum Dates: From ____/____/____ - ____/____/____ Hours: _____

2. Clinic/Site: _____ Phone: (____) _____

Name of Preceptor: _____ Family Peds Other: _____

Practicum Dates: From ____/____/____ - ____/____/____ Hours: _____

3. Clinic/Site: _____ Phone: (____) _____

Name of Preceptor: _____ Family Peds Other: _____

Practicum Dates: From ____/____/____ - ____/____/____ Hours: _____

Practicum Scope

Briefly describe two learning goals you wish to achieve during this practicum.

1. _____

2. _____

Briefly describe one career goal you wish to achieve.

1. _____

Process and Procedure

- Step 1: Email completed application to Carolina Health Centers, Inc.
- Step 2: Applications are forwarded to schedulers for pediatric and/or family medicine departments
- Step 3: CHC will contact the applicant should something become available

Email to:
sbotchie@carolinahealthcenters.org