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: _____

Social Security Number: _____

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:
careers@carolinahealthcenters.org