Henry J. Austin Health Center
Nurse Practitioner Residency
Applications 2020 - 2021

Henry J Austin’s mission is to train highly effective, competent and autonomous primary care providers skilled in providing integrated patient-centered care in the FQHC setting. Our goal for new graduate Nurse Practitioners is to provide the depth, breadth, volume, and intensity of clinical training required to serve as primary care providers in the complex setting of community health centers.

Eligibility Requirements:
- Graduate of a Master’s or Doctoral Graduate Nurse Practitioner program within 2 years of applying for entrance into the program
- ANCC/AANP certification exam eligibility with intention to take a certification exam before July 2020
- New Jersey State APRN licensure eligible
- Federal DEA certificate eligible
- Bilingual preferred

Application Requirements:
- Application
- CV (with 5-year work history)
- Essay responses to the following prompts
- Three letters of reference
- ANCC/AANP certification or evidence of eligibility for certification (when available)
- Copy of Registered Nurse License
- Copy of APRN License (if already available)
- Written confirmation of eligibility of NP program graduation
- Headshot photo (used for identification purposes only)
- Color copy of Graduate Degree or Diploma
**Essays:**

Please submit essay responses to the following questions. This is an opportunity to communicate to HJAHC your personal statement of qualifications, interest, and motivation in acceptance to this residency.

- What personal, professional, educational and clinical experiences have led you to choose nursing as a profession, and the role of an Advanced Practice Nurse in Primary Care in an under-served urban or rural community? What are your aspirations for a residency program? Please comment upon your vision and planning for your short and long-term career development.

- What are the goals that you are looking to accomplish during your residency at HJAHC? Please identify specific areas of interest by lifecycle, age, or setting that in which you would like to develop increased mastery, competence or confidence.

- HJAHC’s residency program is a unique interdisciplinary residency with physicians, nurse practitioners, behavioral staff, clinical pharmacists, and dentists who learn and work alongside each other. Please comment on your personal qualities and strengths that you think will contribute positively to the program. What apprehensions, concerns, and hesitations do you have? Please feel free to be straightforward!

**Letters of Reference:**

Please have the reference letters mailed directly to you and then submitted within the packet. Please have the references include an email address or phone number at which they can be reached if necessary.

- 1 letter from either an employer or clinical preceptor
- 1 letter from an advisor/NP Faculty/Program Director providing a brief assessment of your capabilities for this residency
- 1 letter from the Associate Dean indicating your cumulative GPA, academic standing and verifying graduation criteria will be fulfilled by June 2019
Henry J. Austin Health Center
Nurse Practitioner Residency
Application for 2020-2021

Name: ____________________________________________

Last   First   Middle   Degree

Address: _____________________________________________

Street   City/State   Zip

Phone: (___)_____ - ________(preferred)   (___)_____ - ________(alternate)

Email: ____________________________________________  Years of RN experience: ______

Graduate University: _____________________ Proficient Language(s): ____________________

CLINICAL ROTATIONS/FELLOWSHIPS/PRECEPTORSHIPS
List in chronological order—include month/year of attendance, clinical hours, full mailing

directory of clinical institution & preceptor/attending provider’s name/title. (Attach additional

page if needed)

Clinical Institution: _____________________________________________

Dates_____/_____/_____ to _____/_____/______  Hours Completed: ________________

Address: _____________________________________________

Street   City/State   Zip

Specialty: _____________________  Preceptor: _____________________

******************************************************************************

Clinical Institution: _____________________________________________

Dates_____/_____/_____ to _____/_____/______  Hours Completed: ________________

Address: _____________________________________________

Street   City/State   Zip

Specialty: _____________________  Preceptor: _____________________

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Clinical Institution: ________________________________

Dates _____/_____/_____ to _____/_____/_____

Hours Completed: ______________________

Address:

Street __________________________ City/State Zip

Specialty: __________________________ Preceptor: __________________________

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Clinical Institution: ________________________________

Dates _____/_____/_____ to _____/_____/_____

Hours Completed: ______________________

Address:

Street __________________________ City/State Zip

Specialty: __________________________ Preceptor: __________________________

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POST GRADUATION/BOARD CERTIFICATION STATUS

1. Are you currently in good academic standing & expect to graduate ‘on time’? Y/N_____

2. What is your actual/expected date of graduation? DATE: _____/_____/_____

3. Have you applied to take the ANCC or AANP certification exam? Y/N___________

4. What is your expected date of ANCC/AANP certification? DATE: _____/_____/_____

5. Are you available to work in any of our designated health center site locations for an intense 12-month professional residency? Y/N___________

6. Do you intend to practice as a primary care provider in a FQHC? Y/N__________

Other Certifications & Memberships

Please note all professional certifications (ACLS, PALS, etc.) and any memberships to professional societies, etc.

__________________________________________________________

__________________________________________________________

Areas of Interest/Specialty: _______________________ (Primary)/__________________ (Secondary)
EMPLOYMENT HISTORY

(Most recent first. Please do not leave anything blank; if the field does not apply, put “N/A”.
*Incomplete resumes will not be viewed, processed, or considered.)

Company Name: __________________________________________
Supervisor Name:__________________________ Supervisor Email: ______________________
Job Title:________________________________________ Dates (Month/Year): _____________
From: __________________________ To: __________________________

Address: ________________________________________________
Street __________________________ City/State __________ Zip __________

Reason for Leaving: _______________________________________
☐ Voluntary  ☐ Involuntary

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Company Name: __________________________________________
Supervisor Name:__________________________ Supervisor Email: ______________________
Job Title:________________________________________ Dates (Month/Year): _____________
From: __________________________ To: __________________________

Address: ________________________________________________
Street __________________________ City/State __________ Zip __________

Reason for Leaving: _______________________________________
☐ Voluntary  ☐ Involuntary

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Company Name: __________________________________________
Supervisor Name:__________________________ Supervisor Email: ______________________
Job Title:________________________________________ Dates (Month/Year): _____________
From: __________________________ To: __________________________

Address: ________________________________________________
Street __________________________ City/State __________ Zip __________

Reason for Leaving: _______________________________________
☐ Voluntary  ☐ Involuntary

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**We may contact the employers listed above unless you indicate those you do not want us to contact.

Employer ____________________________ Reason ____________________________
Employer ____________________________ Reason ____________________________
PROFESSIONAL REFERENCES

Company: ____________________________________________
Name: ___________________________  Relationship: ____________________________
Email: ____________________________  Phone: ________________________________
Years Known: ____________________________

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Company: ____________________________________________
Name: ___________________________  Relationship: ____________________________
Email: ____________________________  Phone: ________________________________
Years Known: ____________________________

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Company: ____________________________________________
Name: ___________________________  Relationship: ____________________________
Email: ____________________________  Phone: ________________________________
Years Known: ____________________________

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List other training and/or special skills (including office machines, vehicular equipment or other equipment) you can operate ________________________________________________
PERMISSION TO RELEASE INFORMATION

I, ____________________________ give permission to ____________________________
(clinical supervisor, faculty member, advisor, associate dean, or chair/program director) to provide
information about me for the purposes of a reference letter for the application to the Henry J. Austin
Nurse Practitioner Residency.

______________________________   ________________________________
Signature                  Date

(Please make appropriate copies of this page & distribute as needed)
ATTESTATION

I ________________________ certify, under penalty of perjury, that all of the above information is true

Print Name

and complete to the best of my knowledge. I further understand that any falsification or omission of any
information may result in denial of employment, or, if hired, may result in my termination.

I certify that the information contained in the Application for Medical Staff Appointment is true and accurate
to the best of my knowledge. I authorize any person, organization or entity listed on this application to
furnish HJAHC any and all information necessary to verify the same, including with respect to my
education, training, qualifications, or previous employment.

I consent to and authorize Henry J. Austin Health Center, Inc. to contact my former employers, references,
and any and all other persons and organizations for information bearing on my qualifications for
employment. I further authorize the listed employers, schools and personal references to give the employer
(without further notice to me) any and all information about my previous employment and education, along
with any other pertinent information they may have. I hereby waive any actions, which I may have against
either party (ies) for providing a good faith reference.

I EXPRESSLY AGREE AND UNDERSTAND THAT IF I AM EMPLOYED BY HENRY J. AUSTIN
HEALTH CENTER, INC., MY EMPLOYMENT, HAVING NO SPECIFIED TERM, IS BASED UPON
MUTUAL CONSENT AND MAY BE TERMINATED AT WILL, WITH OR WITHOUT CAUSE, BY
EITHER PARTY (HENRY J. AUSTIN HEALTH CENTER, INC. OR ME) WITHOUT PRIOR NOTICE
TO THE OTHER. I ALSO UNDERSTAND THAT THIS ASPECT OF MY EMPLOYMENT MAY NOT
CHANGE ABSENT AN INDIVIDUAL WRITTEN AGREEMENT SIGNED BY BOTH ME AND THE
PRESIDENT OF HENRY J. AUSTIN HEALTH CENTER, INC. THIS APPLICATION DOES NOT
CONSTITUTE AN AGREEMENT OR CONTRACT FOR EMPLOYMENT FOR ANY SPECIFIED TIME
PERIOD OR DURATION OR A PROMISE OF ANY SPECIFIC TERMS OR CONDITIONS OF
EMPLOYMENT.

This application is current for 60 days. At the conclusion of that time, if I have not heard from Henry J.
Austin Health Center, Inc., and I still wish to be considered for employment, it will be necessary to complete
a new application.

☐ I Accept

___________________________
Signature

___________________________
Date

Please email apnresidency@henryjaustin.org with any questions you may have.

Thank you for applying to the Henry J Austin Health Center
Nurse Practitioner Residency Program.