HJAHC
HENRY J. AUSTIN HEALTH CENTER
QUALITY CARE CLOSE TO HOME

"Growing the next generation of primary care providers"

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 address 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: _____

****

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: _____

****

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)

<u>EMPLOYMENT HISTORY</u>

(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

****

Company Name: ____

Supervisor Name:___________________________ Supervisor Email: ______________________

Job Title:___________________________________ Dates (Month/Year): _________________

From: To:

Address: ____

Street City/State Zip

Reason for Leaving: ____

☐Voluntary ☐Involuntary

****

Company Name: ____

Supervisor Name:___________________________ Supervisor Email: ______________________

Job Title:___________________________________ Dates (Month/Year): _________________

From: To:

Address: ____

Street City/State Zip

Reason for Leaving: ____

☐Voluntary ☐Involuntary

****

****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: _____

****

Company:_____

Name:_____ Relationship:_____

Email:_____ Phone:_____

Years Known: _____

****

Company:_____

Name:_____ Relationship:_____

Email:_____ Phone:_____

Years Known: _____

****

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 OUR 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.