

**Application Post-Graduate Family Nurse Practitioner Residency Program**

**Vision Statement**: Mohawk Valley Health System Family Nurse Practitioner Residency program envisions a structured program that will provide a high-quality training environment to new graduate nurse practitioners to build upon skills, knowledge, and confidence to deliver effective quality patient care in a primary care provider role. The goal of the program is to eliminate wide variations in on-boarding while improving competency at the entry level. The desired outcomes of the program include improve job satisfaction that would result in provider retention while enhancing provider autonomy and clinical confidence to manage complex patient care within the community.

**Mission Statement:** The mission of Mohawk Valley Health System Family Nurse Practitioner Residency Program is to provide new graduate nurse practitioners a structured environment to build upon entry into practice with supportive clinical rotations and education to enhance clinical performance to deliver competent, high quality health care to the patients and the community they serve in a primary care role.

**Goals of the program**:

* Improve clinical confidence to deliver high quality patient care to the community.
* Increase clinical knowledge through clinical rotations in primary care and various specialty rotations to manage complex patient care.
* Increasing in provider retention and job satisfaction by receiving quality education and training to assist in first year transition as a family nurse practitioner

**Application Requirements:**

1. Official graduate school transcripts
2. One letter of recommendation
3. Three contacts for clinical references
4. Resume or CV
5. Submit a response to the following questions, which questions will assist MVHS in understanding your personal commitment to primary care; reflection on seeking opportunity in a residency program; your interest and motivation.
   1. Describe your motivation to train in a family nurse practitioner residency program and commitment to serve your community as a primary care provider?
   2. What are your personal, professional, education and clinical experiences that led you to the nursing profession and pursuing a role as a family nurse practitioner?
   3. What goals are you seeking to accomplish in the family nurse practitioner residency?

*Please note, all FNP residents will be hired as nurse practitioners at MVHS. All applicants are required to have their RN and advanced practice license, federal DEA, and national certification prior to starting clinical sessions. This is NOT a requirement for the application process but will need to be completed for the on-boarding process.*

**Applicant Basic Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle Initial

Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_

Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Education: List in chronological order**

Institution Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Attendance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Rotations and Preceptorships during Nurse Practitioner Education**

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

Clinical Rotation specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinical Rotation specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinical Rotation specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinical Rotation specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinical Rotation specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Clinical Rotation specialty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Rotation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Practicing Specialty as an RN**

Primary Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Board Certification Status**

Certifying Board and number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certificate Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not certified for which board certification is available, please complete the following:

1. Have you been accepted by the Board to take the examination? Yes \_\_\_\_ No \_\_\_\_
2. Are you actively in the Board Certification Examination process? Yes \_\_\_\_ No \_\_\_\_
   1. If yes, when do you expect to sit for the examination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever taken and filed a certification examination? Yes \_\_\_\_ No \_\_\_\_

**Clinical References: Please provide 3 clinical references with at least one being a peer reference**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**STATEMENT OF APPLICATION AND RELEASE FORM:** (Please read carefully before signing.)

I understand that Mohawk Valley Health System (“MVHS”) is required to privilege and credential practitioners, therefore I agree to make available to MVHS 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 practitioner. 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 practitioner to furnish upon request, all such information to MVHS, 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 all liability, loss, damage, claim or expense of any kind arising from or in connection with, disclosure of information to MVHS 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.

I certify that the information contained within this application is complete and accurate to the best of my knowledge. I understand that any false or missing information may disqualify me from consideration for a position or if employed may constitute cause for termination.

Printed Name

Signature

Date

Please submit your completed application by Mail:

Deadline **May 1, 2023**

MVHS Whitesboro Medical Office

ATTN: Jennifer D’Onofrio, FNP-BC

37 Main Street

Whitesboro, NY 13492

Or by Email: JDonofri@MVhealthsystem.org