2014 NURSE PRACTITIONER RESIDENCY

Glide Health Services
in partnership with
UCSF School of Nursing and Community Health Center, Inc.

APPLICATION INSTRUCTIONS

Thank you for your interest in the Nurse Practitioner Residency in Primary Care at Glide Health Services (GHS) in San Francisco. This residency is designed for new nurse practitioners with a commitment to serve disadvantaged adult populations. The Nurse Practitioner Residency Program at Glide Health Services prepares NPs to become competent primary care providers, builds upon clinical education and evidence-based practice acquired in nursing schools, and develops operational confidence necessary in a Federally-Qualified Health Center (FQHC).

Our program will support a total of two residents each year.

The following items are required to complete the application process:

1. 2014 NP Residency application
2. Essay, in which prompts A, B, C are addressed
3. Curriculum vitae/résumé
4. Credentialing Application for Nurse Practitioners (attached)
5. Four (4) letters of recommendation, sealed with signatures.
   a. one (1) letter must come from an academic instructor.
   b. one (1) letter must come from a preceptor.
   c. two (2) letters must come from a place of employment. At least one must come from a professional supervisor or manager. The second letter can come from a coworker.

The completed NP Residency application should be mailed to the address below:
Glide Health Services
NP Residency Program Coordinator
330 Ellis Street Suite 511
San Francisco, CA 94102

Application Dates:

- Applications are accepted on a rolling basis until October 1, 2013
- The selection process will be completed in November 2013
- NP Residents will begin their first day on December 9, 2013

If you have any questions, please email the NP Residency Program Coordinator:

- NPResidency@glide.org
Application Requirements

1. Since all residents will be credentialed providers at GHS, all applicants are required to fill out the following attached Credentialing Application for Nurse Practitioners.

2. Please submit responses to the following questions in an essay format. This is an opportunity to reflect upon and communicate to GHS your personal statement of qualifications, interest, and motivation in acceptance to this Residency. Please do not exceed two, double-spaced pages.

   A. What personal, professional, educational and clinical experiences have led you to choose nursing as a profession, and the role of an/a adult/family nurse practitioner as a specialty practice? What are your aspirations for a Residency program? Please comment upon your vision and planning for your short and long-term career development.

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

   C. The GHS Residency for Nurse Practitioners is still a newly implemented concept, and as such, will require the residency class to participate in some degree as “co-creators” of this model. Please comment on your personal qualities and strengths that you think will contribute positively to this experience. What apprehensions, concerns, and hesitations might you have?

3. Letters of Recommendation

   Letter of recommendation/reference should be from:
   [a] one academic instructor, preferably a nurse. If you are a school of nursing graduate within the past five years, send a letter preferably from a professor who can assess your clinical performance and judgment in the area in which you wish to study; [b] one from a clinical preceptor; and [c] two from a place of employment. At least one of these two letters must come from a professional supervisor or manager. The second letter can come from a coworker.

   ***Please submit at least one letter that specifically addresses your capabilities and interest related to this Residency Program***

   Each recommender is asked to address the following areas, as appropriate:
   [1] relationships with team members such as nurses, physicians, and others;
   [2] professional nursing ability, including application of clinical and investigative skills for the evaluation of health outcomes; use of theory and independent judgment where appropriate, and quality of patient care;
   [3] communication skills;
   [4] leadership skills;
   [5] responsibility and initiative; and
   [6] technological skills and e-health record literacy

   An overall rating from zero to ten is also requested.
PROVIDER CREDENTIALING APPLICATION – APRN

APPLICATION REQUIREMENTS

Please type or legibly print all responses and complete application in its entirety.

COMPLETE ADDRESS AND TELEPHONE NUMBERS ARE REQUIRED WHERE INDICATED.
ALL DATES MUST INCLUDE MONTH AND YEAR.

All questions must be answered and you may not indicate “SEE CV,” etc for a response. If a question is not applicable, “note N/A.” Attach additional sheets if there is insufficient space on the application for your response. As indicated by the checkmark (“✓”) below, current copies of the following documents must accompany your application. Please make sure all copies are legible.

✓ CV with MONTH & YEAR for WORK & EDUCATION history, please include past 5 years of work
✓ If applicable, written & signed explanation of any gaps in work history over (3) months
✓ Copies of RN and Advanced Practice Nursing licenses – website verification is not accepted
✓ Copies of license(s) from any other state – website verification is not accepted
✓ Federal DEA certificate
✓ ANCC / AANP certification or evidence of eligibility for certification
✓ Copy of driver’s license
✓ Four (4) signed and sealed recommendation letters
✓ Proof of professional diplomas (BSN, MSN)
✓ If applicable, non U.S. residents must provide a copy of their permanent resident card/VISA
✓ If applicable, proof of U.S. citizenship (either a U.S. passport-OR-unexpired ID card or unexpired State Driver’s License AND a Social Security Card.
✓ Signed statement by a medically licensed independent provider attesting to your overall health status from your last physical – free of communicable diseases, ability to perform your job functions, etc. This statement must be from a physical exam within the last 12 months.

PLEASE NOTE:
• We require that copies of all licenses (CA license, CA furnishing number & Federal DEA, if available) be authenticated. You may submit a license to GHS in one of two formats:
  (1) the original employer license card or
  (2) write on your photocopy “I certify this photocopy from the original license” and sign and date it.

• Accepted applicants are expected to have active California RN and NP licensure by October 1, 2013. A condition of acceptance is an active California license. Out-of-state applicants are encouraged to begin their application for California licensure immediately. Licensing information can be obtained from www.rn.ca.gov web site.

• The residency program is a 12-month commitment. No extensions will be granted. Individuals who seek leave of absence while in the program may lose their appointment.
PROVIDER CREDENTIALING APPLICATION

PERSONAL INFORMATION

Provider Name: ____________________________________________________________

Last     First          Middle   Degree

Maiden/Other Name used During Professional Career: ____________________________________________________

Residence Address: _____________________________________________________________________________

Street     Suite/ Apartment #

City       State          Zip Code

Telephone #: ____________________________

Date of Birth: _________________    Place of Birth:____________________   email address:__________________

Social Security Number________________    Citizenship____________________ (if other than US, provide copy)

Please list any languages other than English spoken by you______________________________________________

LICENSURE/ REGISTRATIONS

A. Medical: List all current and past licenses and specify type. Indicate restrictions on any current or prior license.

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<th>State</th>
<th>Country</th>
<th>Type</th>
<th>Number</th>
<th>Year Issued</th>
<th>Expiration Date</th>
<th>Restrictions</th>
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B. Federal Controlled Substance Registrations: (Circle or list authorized schedules, if applicable)

Federal DEA Number ________________ Expires__________ Schedules: 2  2N  2  3N  4  5 (circle each)

C. National Provider Identifier (NPI): ________________________________

NPI login ___________________ NPI password ___________________

You may call 1-800-465-3203 to obtain this information if you do not know your login and password. NPI will not release this information to a third party.
EDUCATION

List education in chronological order – include **month/year** of attendance and graduation and **full mailing** address of institution.

**Undergraduate:**
Institution __________________________________________________ Dates ______ to ________
Complete Address:____________________________________________________________________
Degree Awarded __________________________ Date of Degree __________________________

**Medical:**
Institution __________________________________________________ Dates ______ to ________
Complete Address:____________________________________________________________________
Degree Awarded __________________________ Date of Degree __________________________

**Other Graduate/Professional (PhD, MPH):**

Complete Address:____________________________________________________________________
Complete Address:____________________________________________________________________
Degree Awarded __________________________ Date of Degree __________________________
ROTATIONS/FELLOWSHIPS/PRECEPTORSHIPS

If applicable, list in chronological order – include month/year of attendance and full mailing address of institution.

Rotation 1:
Complete Address:___________________________________________________________________
Degree Awarded______________________________ Date of Degree________________________
Specialty__________________________ Program Director_______________________________

Rotation 2:
Complete Address:___________________________________________________________________
Degree Awarded______________________________ Date of Degree________________________
Specialty__________________________ Program Director_______________________________

Rotation 3:
Complete Address:___________________________________________________________________
Degree Awarded______________________________ Date of Degree________________________
Specialty__________________________ Program Director_______________________________

Rotation 4:
Complete Address:___________________________________________________________________
Degree Awarded______________________________ Date of Degree________________________
Specialty__________________________ Program Director_______________________________

Other:
Complete Address:___________________________________________________________________
Degree Awarded______________________________ Date of Degree________________________
Specialty__________________________ Program Director_______________________________
### PRACTICING SPECIALTY

Primary Specialty

Secondary Specialty

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### BOARD CERTIFICATION STATUS

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<tr>
<th>Field/Specialty</th>
<th>Certifying Board</th>
<th>Certificate Number</th>
<th>Certified</th>
<th>Recertified</th>
<th>Expires</th>
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If not certified in one or more of your practicing specialties for which board certification is available, please complete the following, indicating the specialty(ies) to which your responses apply.

Have you been accepted by the board to take the examination and are you actively in the board certification examination process? YES _____ NO _____

If yes, indicate the year by which you must complete the process according to the board’s requirement ______

Have you ever taken and failed a certification examination? YES _____ NO ______

If yes, indicate the portion(s) failed and the year. Written_____ Oral_____

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### OTHER CERTIFICATIONS/MEMBERSHIPS

Indicate type or field in which certified (examples: use of specific laser, BLS, ACLS, ATLS, etc.), date acquired, date expires, if applicable and organization issuing the certificate. Also include memberships to IPAs, medical societies, AMA, etc.

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<thead>
<tr>
<th>Certification</th>
<th>Certifying Organization</th>
<th>Date Received</th>
<th>Date Expires</th>
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REFERENCES

Provide two (2) professional peer references:

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<tr>
<th>Name</th>
<th>Full Address</th>
<th>Telephone</th>
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<td>2.</td>
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Provide two (2) references from a supervisor/instructor

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<th>Name</th>
<th>Full Address</th>
<th>Telephone</th>
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PROFESSIONAL LIABILITY INSURANCE

Include a copy of the malpractice insurance facesheet from your current employer. All applicants must have individual malpractice insurance.

Current Company___________________________________________ Policy #__________________

Full Address______________________________________________________________________

_____________________________________________________________________________________

Effective Date______________ Expiration Date______________ Amount of Coverage_______________

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual surcharge placed on you based on your individual experience? YES ___ NO _____

If yes, please explain:_____________________________________________________________________

_____________________________________________________________________________________

Have you ever had any malpractice actions brought against you or judgments or settlements made, or do you have any cases pending? YES ___ NO _____

If yes, please explain:_____________________________________________________________________

_____________________________________________________________________________________
**DISCIPLINARY/OTHER ACTIONS**

Have any of the following ever been or are any currently in the process of being denied, revoked, suspended, reduced, limited, made subject to probationary terms, or not renewed? Or have you relinquished or withdrawn or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional conduct? If yes, please provide a full explanation on a separate sheet.

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<tr>
<th></th>
<th>YES</th>
<th>NO</th>
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<tr>
<td>License/registration to practice in any state</td>
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<td>DEA/controlled substance registration</td>
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<td>Membership on any hospital staff</td>
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<td>Clinical privileges at any hospital</td>
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<td>Participation in Medicare, Medicaid or other payor programs</td>
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<td>Non-hospital practice affiliation or authorization to provide services</td>
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<td>Board certification</td>
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<td>Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you?</td>
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<td>Have you been convicted of or pleaded no contest to a drug or alcohol related offense?</td>
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<td>Have you been sanctioned by a PPO or similar federal or state agency?</td>
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HEALTH STATUS

If any of the following questions are answered in the affirmative, please provide full explanation on a separate sheet.

Do you presently have a physical or mental health condition, including alcohol or drug abuse, that affects or that may reasonably be expected to progress within the next two years to the point of affecting your ability to practice your profession or place your patients at increased risk?

YES ___ NO _____

Are you currently taking medication/under other therapy for a condition that could affect your ability to perform professional duties if the medication/therapy were discontinued today?

YES ___ NO _____

Have you at any time during the past ten years been hospitalized or received any other type of institutional care for any such condition/problem?

YES ___ NO _____

Are you free of communicable diseases? YES ___ NO _____

Are you able to perform the functions of your job? YES ___ NO _____

Most recent physical examination: Date____/____/____

Performed by___________________________________________________________________________

Significant findings_________________________________________________________________________

_____________________________________________________________________________________

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

I understand that GHS/URM is required to credential and recredential providers every two years and therefore, I agree to make available to GHS/URM 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 provider.

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 provider to furnish upon request, all such information to GHS/URM 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 any and all liability, loss, damage, claim or expense of any kind arising from or in connection with, disclosure of information to GHS/URM 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.

Print Name__________________________________________________________

Signature ____________________________________________________________________________

Date __________________
NOTICE OF BACKGROUND CHECK AND FAIR CREDIT REPORTING ACT DISCLOSURE

As part of the interview process, GHS/URM may conduct a background check. If you are hired, GHS/URM may also conduct a background check in deciding whether to continue your employment and when making other employment-related decisions directly affecting you. As part of the background check, GHS/URM may obtain a “consumer report” from a “consumer reporting agency.” These terms are defined in the Fair Credit Reporting Act (“FCRA”), which applies to you. A consumer report includes information regarding such issues as your credit standing, criminal record, motor vehicle record, character and reputation. If GHS/URM obtains a “consumer report” about you, and considers any information in the “consumer report” when making an employment-related decision that directly and adversely affects you, you will be provided with a copy of the report before the decision is finalized.

You may also contact the Federal Trade Commission in Washington, D.C., about your rights under the FCRA as a consumer with regard to “consumer reports” and the “consumer reporting agencies” that prepare these reports. Your signature below authorizes GHS/URM to obtain consumer reports regarding you from consumer reporting agencies in connection with your application and during the course of your employment.

To perform the background check, please provide the following information:

Social Security No.: _____ - _____ - ______ Date of Birth: _________________

Driver’s License No: ____________________ State: ____________

Signature: ______________________________

Print Name: ____________________________

Print Former Name: _____________________ Date: __________
AUTHORIZATION TO COLLECT BACKGROUND INFORMATION

I have applied for employment at GHS/URM I authorize investigation of all statements contained on my resume and in this application for employment as may be necessary in arriving at an employment decision. I authorize representatives of GHS/URM to obtain pertinent information from my previous employers, references, and other persons with knowledge of my work history and background, financial history, education, regulatory or police records, driving records, licensing status or professional designation, and character or reputation, and to consider the information provided by the background check when making decisions regarding my employment at GHS/URM.

I authorize all previous employers, references or other persons having knowledge of my record or myself to release such information to GHS/URM, and hereby release all persons from liability for any damage that may result from furnishing such information to GHS/URM.

A photocopy of this authorization may be accepted in lieu of the original.

Signature: _____________________________ 

Print Name: _____________________________

Print Former Name: _____________________________ Date: ______

During the past 7 years I have lived at the following addresses and under the name of:

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ATTESTATION QUESTIONS

Please answer the following questions “yes” or “no.” IF YOUR ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS “YES,” PLEASE PROVIDE FULL DETAILS ON A SEPARATE SHEET.

**Professional Liability Insurance:**

__Yes __No  Has any medical malpractice judgment been entered against you in any professional liability case(s)?

__Yes __No  Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make a monetary payment?

__Yes __No  Are you aware of any malpractice claims currently pending/under investigation against you?

__Yes __No  Has any policy been canceled, or has any professional liability insurance refused to renew your policy or place limitations on the scope of your coverage?

*Please note that members of this Healthcare organization shall report to this Healthcare Organization the disposition (including settlement) and/or final judgment in professional liability cases in which they are involved, within thirty (30) days after disposition and/or final judgment.*

**Physical and Mental Health:**

__Yes __No  Do you currently have, or have you had a problem associated with the use or misuse of drugs or controlled substances of any kind (whether obtained by prescription or otherwise), or alcohol? If yes, on a separate sheet please give a full explanation, including, without limitation, frequency and amount of use, the time period in which you engaged in such use, and the date last used.

__Yes __No  Do you have any reason you cannot safely perform all the essential mental and physical functions related to the specific clinical privileges you are requesting or required by your agreement with the medical staff or professional staff bylaws of the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance, and without posing a significant health and safety risk to others? If yes, on a separate sheet, please describe the essential function(s) and state the reason why you may not be able to safely perform it.

**Disciplinary and/or Voluntary Actions:**

Voluntary ***or involuntary, have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently pending/under investigation?

__Yes __No  Professional license or certificate in any state;

__Yes __No  Employment on the staff of any institution;

__Yes __No  Any other type of professional sanction;

__Yes __No  Have you been subject to any disciplinary action in any health care organization, or is such action pending;

__Yes __No  Has any addition supervisory requirement been imposed;
ATTESTATION QUESTIONS

__Yes __No  Have you resigned or taken a leave of absence in order to avoid possible suspension, or reduction of duties at any hospital or institution;

__Yes __No  Have there been any, or are there any, misdemeanor or felony criminal convictions against you, including those under the Criminal Control Act;

__Yes __No  Have there been any, or are there any, misdemeanor or felony criminal charges pending against you including those under the Criminal Control Act;

***For the purpose of answering these questions, a “Voluntary” termination is considered a disciplinary action when the relinquishment is done to avoid an adverse action, preclude an investigation, or is done when the provider is under investigation related to professional conduct. You do not need to report resignations for reasons of relocation or change of activity

Compliance with Laws Related to Patient Care:

__Yes __No  Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you failed to comply with laws, statutes, regulations, or other legal requirements that may be applicable to the practice of your profession or to your rendition of service to patients?

__Yes __No  Are there any prior or pending government agency or third party payer proceeding or litigation challenging or sanctioning your patient treatment, charging, collection, or utilization practices including, but not limited to, Medicare and Medicaid fraud and able proceedings or convictions?

__________________________________   ____________________________________
(Signature)       (Date)

__________________________________   ____________________________________
(Please print name here)          (Practice site)
APPLICANT'S AGREEMENT AND CERTIFICATION

I certify that the answers given in this application are true to the best of my knowledge.

I understand that the use of this application form does not indicate that there are any positions open and does not in any way obligate GHS.

I understand that should I be granted an interview, no representations that may be made at the interview are to be construed as creating any obligation, promise or contract on behalf of GHS.

I understand that the lack of truthfulness, misleading information or material omissions given in my application, resumes, interview(s) or during the course of my employment are grounds to terminate the hiring process or employment whenever they are discovered.

I understand that acceptance for employment shall depend on satisfactory replies from my references and other background checks.

I have read, understood and agree to the foregoing.

Print Name__________________________________________

________________________________________________________________________

__________________________________________

Signature