

**Advanced Practice Professionals
Clinical Internship Application**

Student

Name: _____

Email: _____ Phone: _____

Are you a current Erlanger employee? _____ If yes, what department? _____

Have you ever been employed by Erlanger Health System? _____

If yes, when? _____ What department? _____

Academic Institution

Name: _____

Program: _____

Contact Name & Title: _____

Email: _____ Phone: _____

Clinical Request

Rotation Type (Specialty): _____

Total hours: _____ Start Date: _____ End Date: _____

Have you contacted anyone at Erlanger regarding serving as your preceptor? _____

If yes: Potential Preceptor Name: _____ Dept.: _____

Potential Preceptor Name: _____ Dept.: _____

Potential Preceptor Name: _____ Dept.: _____

Submit completed application to nancy.stevens@erlangers.org