ThriveWell Medical Center

Student Preceptorship Application

I appreciate your interest in completing a clinical preceptorship with ThriveWell Medical Center. Our program is designed to provide hands-on, community-focused learning experiences in primary care, mental health, oncology survivorship, women's health, and preventive care within a medically underserved community. Submission of this application does not guarantee placement.

Applicant Information

Full Name:

Preferred Name:

Date of Birth:

Email Address:

Phone Number:

Mailing Address:

City, State, ZIP:

Academic Program Information

School or University Name:

Program of Study:

Degree Pursued:

Current Year in Program:

Expected Graduation Date:

Academic Advisor Name and Contact Information:

Licensure and Certifications

Current License or Certification Held, if applicable:

License Number and State, if applicable:

BLS Certification Expiration Date:

Additional Certifications, if any:

Preceptorship Details

Course Number:

Requested Start Date:

Requested End Date:

Total Clinical Hours Required:

Preferred Clinical Focus Areas, check all that apply:

☐ Primary Care ☐

☐ Mental Health ☐

☐ Oncology Survivorship ☐

☐ Community Health and Preventive Care ☐

☐ Women's Health ☐

Days and Times Available:

Are you required to meet specific program competencies or objectives?
-If yes, please attach documentation.

Statement of Interest

Please provide a brief statement, up to one page, describing your interest in completing a preceptorship at ThriveWell Medical Center, your career goals, and how this experience aligns with your academic and professional objectives.

Prior Clinical Experience

Please summarize any prior clinical or healthcare-related experience, including settings, roles, and populations served.

Background and Compliance

Have you ever been convicted of a felony or misdemeanor that may impact clinical placement? Yes / No

If yes, please explain:

Are you able to meet clinical site requirements, including background check, drug screening, and HIPAA training? Yes / No

Required Attachments

☐ Current resume or CV

☐ Statement of interest

☐ Proof of BLS certification

☐ Prior Clinical Experience statement

☐ School preceptorship requirements or objectives, if applicable

Applicant Attestation

I certify that the information provided in this application is true and complete to the best of my knowledge. I understand that submission of this application does not guarantee placement and that acceptance is contingent upon program availability, school requirements, and ThriveWell Medical Center approval.

Applicant Signature:

Date:

Submission Instructions

Please submit your completed application and all required attachments by email to:

ThriveWell Medical Center

Email: **info@thrivewellmedicalcenter.com**

Subject Line: Student Preceptorship Application