**Transition to Practice Fellowship Application**

For Physician Assistants and Nurse Practitioners

1. **Transition to Practice Fellowship at St. Thomas Community Health Center Program Overview.**

This program is a 12-month postgraduate Transition-to-Practice fellowship designed specifically for Physician Assistants (PAs) and/or Nurse Practitioners (NPs) who have, or will have, graduated from a PA or NP program respectively. The program is based within the St. Thomas Community Health Centers located in New Orleans and on the West bank. St. Thomas CHC is a Federally Qualified Health Center (FQHC) which addresses the health care needs of an underserved population.

This Transition to Practice Fellowship program is designed for a new PA or NP transitioning into clinical practice. The program offers a structured curriculum which includes on-site didactic teaching along with active clinical experiences and training. The focus is strictly on an outpatient clinical experience providing primary care to patients of all ages.

Some examples of the clinical rotations will include the following areas (listed alphabetically):

* Cardiology
* Family Medicine
* Infectious Disease (including HIV, hepatitis, etc.)
* Optometry
* Rheumatology
* Social Services
* Pulmonology
* Psychiatry
* Women’s Health

1. **Program Requirements**

PAs – full licensure is not required for new graduates but there must be a clear pathway toward full licensure including taking and passing the Physician Assistant National Certifying Examination (PANCE) as soon as possible following graduation from a PA program

NPs - A full and unrestricted Louisiana nursing license and 3-5 years clinical nursing experience

Satisfactory completion of a PA or NP program

1. **Required Documents**
   1. **Statement of Interest** - One typewritten page describing career goals and motivation for pursuing the Transition to Practice Fellowship Program and how it will enhance your career.
   2. **Graduate School Transcripts (official)**
   3. **Three Letters of Recommendation –** Letters must reflect clinical performance and must be from a person qualified to comment on your qualifications in your patient care setting. For PAs, one of these letters must come from the director of the PA program. For NPs, one letter MUST be from an attending physician (MD/DO). If you have not worked with an attending physician, one MUST come from your NP program director.
   4. **Curriculum Vitae**
   5. **Professional Photo**
   6. **Application Form** – Completed form with original signature.
   7. For NPs, LSBN Approval Letter - Provide a letter of approval issued by the Louisiana State Board of Nursing indicating approval for prescriptive authority (PA) privileges in the state of Louisiana. Although this letter may not be available upon starting the fellowship, it is required such a letter is provided within the first three months.
2. **Policies Regarding Fellowship Appointment**

St. Thomas Community Health Center (STCHC) will conduct a background check.

St. Thomas Community Health Center is committed to equal employment opportunity as a sound business practice. Employment practices will not be influenced or affected by an applicant's or employee's race, color, religion, sex, sexual orientation, national origin, age, disability, or any characteristic protected by law.

Candidates accepted into the St. Thomas Community Health Center will require a two-year employment contractual commitment upon completion of the 12-month Fellowship program.

1. **Applicant Information**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Middle Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Name(s) legally known by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apartment / Unit # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip:­­\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any languages other than English that you speak with

sufficient proficiency to independently provide nursing care.

(Leave blank if none)

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Are you able to work in the US without sponsorship? Yes\_\_\_ No \_\_\_

Have you ever been convicted of a felony? Yes \_\_\_ No \_\_\_

If yes, please provide details of conviction including dates on separate page and including with your application submission.

Do you have any friends or relatives that work at STCHC? Yes\_\_\_ No \_\_\_

If yes, please provide name(s) & relationship. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you currently reside in a medically underserved community? Yes\_\_\_ No \_\_\_

Please list any Community-Based Health Clinic and/or Federally Qualified Health Center experience and dates:

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Did you graduate or will you graduate from an accredited PA, DNP, or MSN program before July 1, 2024? Yes \_\_\_ No \_\_\_

State your date of graduation from PA or NP program (anticipated or actual).

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Name of the institution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any existing (military or other) service obligations? Yes \_\_\_ No \_\_\_

Are there any current or future obligations that may impair your ability to complete this 12-month fellowship program and the additional 2-year employment contract?

Yes \_\_\_ No \_\_\_

Have you ever been the subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agencies for either conduct-based or performance-based actions? Yes \_\_\_ No \_\_\_

If yes, please provide an explanation. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have a current and fully unrestricted Louisiana PA or nursing license?

Yes \_\_\_ No \_\_\_ Not eligible to apply yet \_\_\_

If no, please provide an explanation on a separate page and including with your application submission.

Have you ever had any action or restriction on your PA or nursing license by any state board of medicine or nursing?

Yes\_\_\_ No\_\_\_ Not applicable \_\_\_

If yes, please provide a detailed explanation on a separate page and include it with your application.

Are you able to perform the essential duties of the fellowship which you are applying?

Yes \_\_\_ No \_\_\_

1. Fellowship specific questions.
   1. Why do you want to complete a Transition to Practice Fellowship?

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* 1. What health-related, community, or personal experiences or activities have you participated in that have prepared you to work with those living in medically underserved areas?

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1. What is your most valued quality in a preceptor/mentor?

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1. **Voluntary Information**

Date of Birth (MM/DD/YYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender (at birth): Male \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Female \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Origin:

\_\_\_\_\_ African American

\_\_\_\_\_ American Indian/Native American

\_\_\_\_\_ White, Non-Hispanic

\_\_\_\_\_ Asian/Pacific Islander

\_\_\_\_\_ Hispanic

\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you or have you ever been in the Armed Forces of the United States?

Yes \_\_\_ No \_\_\_

If yes, branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Service: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you honorably discharged? Yes \_\_\_ No \_\_\_

If no, please provide detailed explanation.

1. **Disclaimer and Signature**

I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.

I authorize St. Thomas Community Health Center and its agents to make investigations and inquiries into my employment and educational history and other related matters as may be necessary in arriving at the employment decision. I hereby release employers, schools, and other persons from all liability in responding to inquiries connected with my application and I specifically authorize the release of information by any schools, businesses, individuals, services, or other entities provided on my employment application. Furthermore, I authorize the company and its agents to release any reference information to clients who request such information for purposes of evaluating my credentials and qualifications.

**Applicant Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please submit all application documents to [ttpfellowship@stthomaschc.org](mailto:ttpfellowship@stthomaschc.org)