PRACTICE EXPERIENCE AGREEMENT AND LEARNING PLAN

Student Name ______________________________ Banner ID __________________________

Student E-mail _____________________________ Concentration ______________________

Practice Experience Advisor __________________ Academic Advisor ___________________

Practice Experience Site ____

Address ____

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Preceptor __________________________________ Title ___________________________

Phone ____________________________________ E-mail __________________________

Practice Experience Registration – check one:

☐ Summer 20_____ ☐ Fall 20_____ ☐ Spring 20_____

Check one: Full Time __________ Part Time __________

Check one: Unpaid ______________ Paid ________ (Stipend: _______ per _______)

Practice Experience – Start date ______________________ End date ____________________
approximate

Midpoint Review Date (with Practice Experience Advisor & Preceptor) ____________________
approximate

Individualized Practice Experience

The following three documents are required for a complete learning plan. Please complete the appropriate forms and submit with this document:

1. Brief **written description** of practice experience (or attach job description provided by preceptor).
2. ***Competency to Activity Form***, with specific activities for accomplishing learning goals.
3. ***Timeline*** for practice experience (see examples).

Requirements for Completion of Practice Experience

1. Register for CMH 594-01 (Practice Experience in Community Health)
2. Approval of Practice Experience and Preceptor by Practice Experience Faculty Advisor
3. Participation in required preparation sessions/activities
4. Completion of all Practice Experience Forms as listed in the guidelines
5. Completion of Midpoint Review with Practice Experience Advisor and Preceptor
6. Completion of 360 contact hours
7. Completion of final forms/activities at end of Practice Experience – insure that Preceptor completes his/her final evaluation
8. Submission of all required Practice Experience Forms to Practice Experience Coordinator

No grade will be given for the Practice Experience until all requirements are met.

Signatures Required for Practice Experience Approval:

Student: ____
(signature) *(date)*

Practice Experience Advisor: ________________________________
(signature) *(date)*

Preceptor: ____
(signature) *(date)*

I have read the Community Health Practice Experience Guidelines and course syllabus and understand the policies, expectations and responsibilities associated with completing my Practice Experience. With respect to my host organization and its clients, I agree to follow federal and state regulations regarding privacy of client information as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ____________________
(Student initials)