

PRACTICE EXPERIENCE AGREEMENT AND LEARNING PLAN

Student Name _____ Banner ID _____ Concentration _____

Advisor _____ E-mail _____

Practice Experience Site _____

Address _____

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 _____

Midpoint Review Date (with Practice Experience Advisor & Preceptor) _____

┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆ ┆

Individualized Practice Experience

The following four documents are required. Please complete on separate pages and submit with this form:

1. Brief description of practice experience (or attach job description, if provided by preceptor).
2. Student Self-Evaluation of Experience and Competence Form.
3. Learning plan based on competencies (use attached Practice Experience Competency to Activity Worksheet), and specific activities for accomplishing the learning plan.
4. Timeline for practice experience (see example).

Requirements for Completion of Practice Experience

1. Register for CMH 594-01 (Practice Experience in Community Health)
2. Signed and approved Practice Experience Agreement and Learning Plan
3. Participation in required preparation sessions/activities
4. Completion of 10 Guided Progress Reports during Practice Experience
5. Completion of Midpoint Review with Practice Experience Advisor and Preceptor during Practice Experience
6. Completion of required number of contact hours
7. Completion of final Practice Experience Evaluation forms/activities at end of Practice Experience (including insuring 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 Manual 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)

Competency to Activity Worksheet

After completing the *Student Self-Evaluation of Experience and Competence* form, indicate, in the table below, the competencies that will be the focus of your practice experience along with the corresponding learning goals and activities you have identified. For the Practice Experience students should choose to focus on at least SIX competencies from the selected domains, including at least ONE concentration domain (#'s 11-14) and at least THREE cross-cutting domains (#'s 1-10), based on their self-evaluations of competence. Indicate the specific activities that you will perform during the practice experience and how they will relate to (i.e. help you achieve) the learning goals. Use as many sheets as necessary.

Competency	Learning Goals	Specific Activities