Choptank Community Health System Inc

Preceptorship Program Application

- The applicant must complete all forms and attach required copies of credentials.
- Electronic signatures will be accepted.
- Once completed, forms can be submitted electronically by email to: tosborn@choptankhealth.org .
- Applicant must assure all scanned copies are legible.
- Contact 410-479-8346 or tosborn@choptankhealth.org for application questions.
- Applicant may begin the program only when the background check and primary source verification have been completed and the applicant is deemed to be clear.

Completing the Application

1: Dental Preceptorship Program Application (two pages). Complete both pages with all applicable information.

2: 2023 Authorization Disclosure Application. Read/complete information/sign/date and return all seven pages.

3: Confidentiality Agreement (one page). Read, complete/sign/date.

4: Required Vaccine Records for non-employed clinical staff at Choptank Community Health (2 pages). Read page one and then complete page two. Attach copies of your immunization records and ppd screenings.

5: Health and Safety Training Acknowledgment (one page). Read, print your name/sign/date.

6: Choptank Community Health System, Inc. Quality and Safety Handbook. Read all pages. The form you complete for number 5 is the attestation that you have read this information.

Documents to Submit with the Application

- Two forms of identification, one of which must be a government-issued photo ID or passport
- Two letters of recommendation
- CPR card
- Cv/Resume
- Dental School Diploma or graduate certificate
- Dental School Transcripts
- Immunization/vaccine records

Application

Last Name: _____

First Name: _____

Middle Name: _____

Telephone Number: _____

Email Address: _____

Current Address/City/State/Zip: _____

_____

Previous addresses for past seven years:

_____

_____

_____

_____

_____

_____

_____

Date of Birth: _____

Social Security Number (if applicable): _____

Visa issued: Yes __ No __ (if so, attach copy)

U.S. Citizen: Yes __ No __

Country of Origin: _____

Immigration status (if applicable): _____

Dental School name: _____

Dental School Address: _____

Dates Attended: _____

Graduation Date: _____ (attach copy of diploma)

By signing this application form, I confirm that all information listed by me is accurate. I certify that I have completed the education required to be eligible for this program, that I am physically and mentally capable to participate in this program, and that I do not have a physical or mental health condition (including alcohol or drug dependence). I understand that information disclosed by me will be verified by Choptank Community Health System Inc. and in the event an adverse finding is made or if I am at any time found to be in violation of the Choptank Community Health System 's Standards of Behavior, I will be removed from the preceptorship program without refund of the program fees paid by me.

Applicant Signature: _____

Applicant Printed name: _____

Date: _____

Submit application and all documentation to:

Tammy Osborn, Credentialing Specialist

Choptank Community Health System Inc

301 Randolph St, Denton MD 21629

410-479-8346 Phone, 410-479-1714 Fax, tosborn@choptankhealth.org