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| **Pediatric Hematology Oncology / Stem Cell Transplant Nurse Practitioner Fellowship Program** | **Icon  Description automatically generated** |  |

**TEXAS CHILDREN’S CANCER AND HEMATOLOGY CENTER
 NURSE PRACTITIONER FELLOWSHIP APPLICATION**

**MAIL TO:** Texas Children's Cancer Center

ATTN:Laura Sealy, DNP, CPNP-AC

6701 Fannin St., Ste. 1580.06

Houston, TX 77030

**FAX TO:** 832-825-9088 (ATTN: Laura Sealy, DNP, CPNP-AC)

**EMAIL TO:** Laura Sealy,DNP, CPNP-AC lesealy@texaschildrens.org

 Julie Klinger jalerou1@texaschildrens.org

Administrative Use Only

**APPLICANT INFORMATION** Date Received:

|  |  |
| --- | --- |
| Name: Last First Middle      | Present Address      |
| Home / Cell phone      |  Work phone      | Social Security Number      |
| Current Home Address      | Permanent Home Address (if different from Current Address)      |
| Are you a U. S. CITIZEN? [ ]  Yes [ ]  NoWill you need local housing information? [ ]  Yes [ ]  NoWill you need local housing information? [ ]  Yes [ ]  No |

**EDUCATION**

|  |  |  |  |
| --- | --- | --- | --- |
|  Undergraduate Education: |  Degree: | From (mm/yy) | To (mm/yy) |
|  Nursing School: |  Degree: | From (mm/yy) | To (mm/yy) |
|  Other Degrees: |  Degree: | From (mm/yy) | To (mm/yy) |

**EMPLOYMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Hospital:       | Title / Responsibilities:      | From (mm/yy)       | To (mm/yy)      |
| Hospital:       | Title / Responsibilities:      | From (mm/yy)      | To (mm/yy)      |
| Hospital:       | Title / Responsibilities:      | From (mm/yy)      | To (mm/yy)      |
| Hospital:       | Title / Responsibilities:      | From (mm/yy)      | To (mm/yy)      |

**PROFESSIONAL LICENSES/CERTIFICATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of License / State      | License #      | Date of Receipt (mm/yy)       | Date of Exp. (mm/yy):      |
| Type of Certification      | Cert. #      | Date of Certification      | If not, Date of Schedule Testing (mm/yy)      |
| Type of Certification      | Cert. #      | Date of Certification      | Date of Exp.      |

**MEMBERSHIP IN HONORARY OR PROFESSIONAL SOCIETIES, PRIZES, AWARDS, PUBLICATIONS**

**SKILLS/COMPETENCIES (Check if competent in these skills)**

[ ]  Physical Exam

[ ]  History Taking

[ ]  Developmental Assessment

[ ]  Bone Marrow Aspiration

[ ]  Bone Marrow Biopsy

[ ]  Lumbar Puncture

[ ]  Intrathecal Chemotherapy Administration

[ ]  IV Starting

[ ]  Needle placement in Port-a-cath

[ ]  Central line catheter care

[ ]  Chemotherapy administration and side effects

[ ]  Interpreting peripheral blood smears

[ ]  Interpreting Bone Marrow slides

[ ]  Teaching families and children about cancer and its treatment

[ ]  Understanding treatment protocols for childhood cancer treatment

[ ]  Managing side-effects of childhood cancer treatment

[ ]  Fundamentals of Hematopoietic Stem Cell Transplant

[ ]  HSCT treatment and side effects

[ ]  Anemias

[ ]  Thrombocytopenias and Coagulopathies

[ ]  Neutropenias

**COMMENTS**

**SUMMARIZE YOUR WORK EXPERIENCE WITH CHILDREN WHO HAVE HAD CANCER, BLOOD DISORDERS OR A HEMATOPOEITIC STEM CELL TRANSPLANT. PLEASE DESCRIBE YOUR INTEREST IN THE FELLOWSHIP PROGRAM AT TEXAS CHILDREN’S. HOSPITAL AND WHY YOU ARE APPLYING. PLEASE TYPE YOUR RESPONSE IN THE SPACE BELOW.**

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** Applicant Signature Date

**REFERENCES**

|  |  |  |
| --- | --- | --- |
| Name and Title | Email Address | Telephone |
|       |       |       |
|       |       |       |
|       |       |       |

Please provide the name and email addresses of professional colleagues, instructors or supervisors who are acquainted with your academic and professional experience.

**Which clinical experiences are you interested in? [Check 4 top interests]**

[ ]  Leukemia

[ ]  Lymphoma/Histiocytosis

[ ]  Hematology – Bone marrow failure

[ ]  Hemostasis / Thrombosis / Vascular anomalies

[ ]  Hematology – Sickle Cell

[ ]  Hematopoietic Stem Cell Transplantation

[ ]  Solid Tumors (bone tumors, liver tumors, retinoblastoma, rare tumors)

[ ]  Neuro Oncology (brain tumors, neuroblastoma)

[ ]  Palliative Care and Developmental Therapeutics

[ ]  Other specialty interests:

**CHECKLIST**

Along with this application, please provide the following:

[ ]  Full CV

[ ]  Letters of Recommendation. Can be emailed to email address below.

[ ]  Texas RN License

I certify that the information submitted in this application is true, complete and accurate. I understand that any misrepresentation will be cause for denial of appointment. Application on line is acceptance of the disclaimer without signature.

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** Applicant Signature Date

**Email to:** **lesealy@texaschildrens.org** **jalerou1@texaschildrens.org**