

# HEALTH COACHING PARTNERSHIP APPLICATION

**SECTION I: PERSONAL INFORMATION** 

First Name Middle Name			Last Name	
PERMANENT ADDRES	S:			
	Street		Apt #	
	City		State	Zip Code
PHONE NUMBER:				
Cell Phone			Other Phone	
EMAIL:				
SECTION II: EMERGENCY CONTACT INFORMATION:				
NAME:				
ADDRESS				
PHONE:				
SECTION III: EDUCATION				
COLLEGE/UNIVERSITY				
MAJOR/DEGREE		YEAR IN SCHOOL		CULMULATIVE GPA
ADDITIONAL LANGUAGES:				

# SECTION IV: APPLICANT CERTIFICATION

\*Please read the following statement in its entirety, and sign below to verify your agreement to the terms.

By my signature below, I certify the information provided above, and any other information in connection with this application form, including the written responses, is true, accurate, and completed by myself, the applicant. I agree that this form in original, faxed, photocopied, or electronic form will be valid for all background reports requested by or on behalf of San Antonio Regional Hospital. I understand that I will be required to submit to a background check and that all parts of the background report must comply with the guidelines set forth by my desired hospital site in order to fulfill the requirements for the Health Coaching Partnership program.

# **SECTION V: QUESTIONS**

- 1. Will you be able to commit to a minimum of six (6) hours per week to the program (this includes the weekly four hour practicum and to reserve time outside of the practicum to visit enrolled participants? **Yes No**
- 2. Will you be able to participate for at least two consecutive academic periods in the Health Coaching Partnership program? **Yes No**
- 3. Will you have your own transportation to the Community Health Improvement Program (CHIP) office in Ontario, and from the CHIP office to the patient's home? **Yes No**
- 4. What days and times are you available outside the practicum to visit patients:

5. Describe any previous experiences in the healthcare setting (use separate page if necessary):

# **SECTION VI: AGREEMENTS**

#### 1. Health Coach Responsibilities: \*Please read and sign\*

Student agrees to a) fulfill all of the responsibilities of the Health Coach described in the Health Coach Program Description; b) attend the mandatory hospital orientation and training seminars, c) commit to a minimum of six (6) hours per week to the program; d) participate for at least two consecutive academic periods or a minimum of 20 weeks; e) commit to attend the weekly four hour practicum (for case reviews, documentation, tele-coaching, etc.) and to reserve time outside the practicum period to visit enrolled participants.

## SIGNATURE OF STUDENT

## 2. Course Credit(s): \*Please read and sign\*

Student, instructor, and departmental chair agree to an assigned (*please circle one*) 0 / 1 / 2 units/credits upper-division course for the (*please circle one*) Winter/Spring/Summer/Fall 2019 period upon completion of the Health Coaching Program.

SIGNATURE OF STUDENT

SIGNATURE OF DEPARTMENT CHAIR

# SIGNATURE OF SAN ANTONIO REGIONAL HOSPITAL

When complete, please scan and email directly to Ronald Nowosad, Director, Program Development and Clinic Operations at **rnowosad@sarh.org**.

DATE

DATE

DATE

DATE