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# Doctor of Public Health Applied Practice Experience

# Approval and Proposal Form

**Semester of APE:  Fall  Spring  Summer Year: 20 Credits:**

|  |  |
| --- | --- |
| **STUDENT IDENTIFICATION** | |
| Name: |  |
| UGA ID (not SS#) |  |
| E-mail: |  |
| Address During Residency: |  |
| Phone Number: |  |
| Cell Phone Number: |  |
|  |  |

|  |  |
| --- | --- |
| **SITE IDENTIFICATION** | |
| Name of Organization: |  |
| Type of Organization: | Non Profit For Profit Gov’t Hospital Other |
| Site Street Address |  |
| Site Mailing Address |  |
| Name of Preceptor:1 |  |
| Title of Preceptor |  |
| Preceptor Qualifications | Degrees: Licenses/Certs: |
| E-mail (Preceptor): |  |
| Phone (Preceptor): |  |
| FAX (Preceptor): |  |
|  |  |

1 If the preceptor changes during the course of the residency, the student must resubmit the proposal with new signatures.

# UNIVERSITY OF GEORGIA - Doctor of Public Health APE Approval and Proposal Form

## Semester of Residency:  Fall  Spring  Summer Year: 20 Credits:

**Name:**

**Site:**

1. **Site Description** (e.g., mission, location(s), programs offered, personnel employed, etc.)

## Project(s) Description

1. **Competencies and Learning Objectives**. Name **five** Competencies with corresponding learning objectives for your Residency. The learning objectives should be clearly linked to the DrPH *program competencies*. For each one, explain in detail the duties or activities that will help you meet these objectives.

NOTE: If significant changes in the learning objectives or task occur during the Residency, they must be submitted in writing to the Academic Advisor and DrPH Practice Coordinator. *Please use the following Format:*

* 1. Competency: (from the program manual)

Learning Objective: (details from your project that will address this competency)

* 1. Competency:
     1. Learning objective(s)
  2. Competency:
     1. Learning objective(s)
  3. Competency:
     1. Learning objective(s)
  4. Competency:
     1. Learning objective(s)

## Signature Page

*My signature below indicates that I have discussed with the student the APE learning objectives and proposed tasks, and that I agree with the proposed learning objectives and related APE activities.*

Student Signature: Date: (SIGNATURE or NAME)



Electronic Submission: by checking this box and adding my name above, I am certifying my approval of this document.

Site Supervisor approval: Date: (SIGNATURE or NAME)



Electronic Submission: by checking this box and adding my name above, I am certifying my approval of this document.

Academic Advisor approval: Date:

(SIGNATURE or NAME)



Electronic Submission: by checking this box and adding my name above, I am certifying my approval of this document.

Practice Coordinator approval: Date: \_ (SIGNATURE or NAME)

Electronic Submission: by checking this box and adding my name above, I am certifying my approval of this document.



Original APE forms will be filed in the College of Public Health Dean’s Office with Practice Coordinator.