MESA COMMUNITY COLLEGE
RN REFRESHER PROGRAM APPLICATION PACKET

Dear Applicant,

Thank you for your interest in MCC’s RN Refresher Program. Please review the entire RN Refresher Program Information Packet posted on our website (www.mesacc.edu/refresher) prior to submitting your application materials. The packet outlines your options for preceptorship/clinical placement, as well as, program enrollment requirements.

**School-Assisted Placement**
If you desire a school assisted clinical placement, please submit the following materials:
1. RN Refresher Program Application form
2. Request for School-Assisted Preceptorship/Clinical Placement form

**Student Finds Own Preceptor**
If you have found your own preceptor, please submit the following materials:
1. RN Refresher Program Application form
2. Preceptor Data Sheet

Send application materials to William Forgione via:

- E-mail: william.forgione@mesacc.edu
- Fax: 480-461-7821
- Postal Service: MCC Nursing, ATTN: William Forgione, 1833 West Southern Ave, Mesa AZ 85202

You will be contacted by a program representative following review of your application materials. If you meet all enrollment requirements, further instructions will be provided at that time.

Please do not hesitate to contact me with any questions.

Sincerely,

William Forgione
William Forgione, MSN, RN
RN Refresher Program Coordinator
Mesa Community College
[william.forgione@mesacc.edu](mailto:william.forgione@mesacc.edu)
480-461-7928
RN REFRESHER PROGRAM APPLICATION

Anticipated Start Date: Semester____________________ Year __________________

Name (PRINT)_____________________________________________________________________________________

Last First Middle

All names previously used: ___________________________________________________________________________

Mailing Address_____________________________________________________________________________________

City________________________________________ State __________________ Zip Code _____________________________

Phone: Day________________________ Evening ___________________ Cell ________________________________

E-Mail Address_____________________________________________________________________________________

RN/TRN License Number ___________________________ Date of Expiration _____________________________

Nursing Schools Attended

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<tr>
<th>Name of School</th>
<th>City/State</th>
<th>Country</th>
<th>Dates Attended</th>
<th>Type of Certificate or Degree</th>
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1. Briefly describe your nursing work history (a preceptorship in a specialty area requires prior experience in that area).

2. How many years have you been out of nursing practice? _______________________________________________

3. How did you hear about this program? _______________________________________________________________

4. If you have found your own preceptor, attach a copy of the signed Preceptor Data Sheet validating your preceptorship placement.

5. If you would like to pursue a school-assisted placement at selected facilities, attach a copy of the Request for School-Assisted Preceptorship/Clinical Placement form.

6. Nurses with Arizona licenses: download & attach a copy of your online license verification ("Services" tab) @ AZBN’s website: http://www.azbn.gov/

RN RefresHERs must possess an unrestricted license to meet eligibility requirements for the NUR295 RN Refresher clinical component of the refresher program. If there are any restrictions on your active, inactive, lapsed, or re-issued license (disciplinary action, monitoring agreement, etc.), MCC is unable to oversee a clinical experience for you.

My signature signifies my acknowledgment of, and compliance with, the following program requirements:

- I have read and understand the RN Refresher Program Information Packet
- My RN license (active, inactive, lapsed, re-issued) is unrestricted.
- I understand that a preceptorship experience in a specialty area (pediatrics, obstetrics, mental health) requires that I have prior RN experience in the selected specialty area (subject to verification w/ a resume/CV).
- I have provided true, correct, and complete information.

Signature: ______________________________________________________________________________________ Date: ___________________
REQUEST FOR SCHOOL-ASSISTED PRECEPTORSHIP/CLINICAL PLACEMENT

Name (print):

_______________________________________________________________________________

1. Select your preference for clinical placement and complete related section below.

[ ] Hospital

[ ] Non-Hospital

[ ] Instructor-led clinical experience under the direction of an MCC faculty member

a. Hospital Placement Requests:
- Are you a former employee of either a Banner or Mayo Clinic facility?

- If you are a former employee of either Banner or Mayo Clinic, what was your job title and what were the dates of your employment?

- Unless you are a former Banner or Mayo employee, all hospital placements are at Maricopa Integrated Health System. Which clinical area would you like to request?

b. Non-Hospital Placement Requests:
- What specific area are you interested in?

- Do you have prior experience in the area listed above? If so, please provide job locations and dates of employment.

c. Instructor-led Clinical Experience:
- All instructor-led clinical experiences will be held at Citadel Post-Acute (citadelpostacute.com)
- Are you able to work at least one 12hr shift each week?
Name of RN Refresher_______________________

**Preceptor Data Sheet**

Name and Credentials (RN, BSN, etc.) __________________________________________

RN License #______________ (Required by Arizona State Board of Nursing)

Number of years practicing nursing _____________

Name of Agency________________________________________________________

Agency Address _________________________________________________________

City ___________________________ State __________ Zip__________

Unit / Unit Telephone # ______________________________

Telephone number where you can be reached: __________________________

Email Address __________________________________________________________

Length of time in clinical practice at this agency: ______________

Have you received an RN Refresher Preceptorship Packet? Yes No

*I agree to accept the role and responsibilities of preceptor for the MCC Nurse Refresher Student.*

Name (print):_________________________________________________________________

Signature: ___________________________ Date:____________________

**Area Supervisor Approval**

Name (print):_________________________________________________________________

Signature: ___________________________ Date:____________________

*For faculty use only:*

*Verification of preceptor licensure completed on:* ______________