SAN ANTONIO REGIONAL HOSPITAL

HEALTH COACHING PARTNERSHIP APPLICATION

SECTION I: PERSONAL INFORMATION

First Name _____ Middle Name _____ Last Name _____

PERMANENT ADDRESS: _____ 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 internship hospital site in order to fulfill the requirements for the Health Coaching Partnership program.

_____ _____

APPLICANT SIGNATURE **DATE**

SECTION V: QUESTIONS

1. Will you be able to participate in the Health Coaching Partnership program for at least two consecutive, 11 week, quarters? Yes No

2. 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

3. Describe any previous experiences in the healthcare setting:

SECTION VI: AGREEMENTS

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

Student agrees to attend the hospital orientation, training seminars, and fulfill all of the responsibilities of the Health Coach described in the attached Position Description. Health coaches are also expected to attend all case reviews, discussions, and presentations during each quarter.

SIGNATURE OF STUDENT	**DATE**

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 2018 period **upon completion** of the Health Coaching Program.

SIGNATURE OF STUDENT	**DATE**
SIGNATURE OF DEPARTMENT CHAIR	**DATE**
SIGNATURE OF SAN ANTONIO REGIONAL HOSPITAL	**DATE**

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