



Dear Applicant,

Thank you for your interest in the INTEGRIS Health Pre-APP Professional Development Internship Program. We are looking forward to reviewing your application.

Listed below are some crucial documents we will need from you. Please allow 4 weeks for processing and 12 weeks for determination of final selection.

Should you have any questions, please reach out to me via email (see below)

Most sincerely,

A handwritten signature in black ink that reads "Sarah Hufstedler, PA-C".

Sarah Hufstedler, PA-C

Lead APP: Surgical Services

Sarah.hufstedler@integrishealth.org



INTEGRIS Health Pre-APP Professional Development Internship Program

General Information:

Name: _____ DOB: _____

Residential Address: _____

Mailing Address: _____

Home Phone: _____ Mobile Phone: _____

Email address: _____

Emergency Contact:

Name: _____ Relationship: _____

Mobile Phone: _____ Home Phone: _____

School information:

University: _____ Year of School: _____

Major: _____

Shadowing area(s) of interest (you may pick up to two):

Primary Care

General Surgery

Orthopedic Surgery

Days and times that work best for you (should come in 2-3x/week): Please Circle

*AM=8am-12pm, PM=1pm-5pm

*Note: this will be subject to change based on the needs of your preceptor as well

Monday		Tuesday		Wednesday		Thursday		Friday	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM



Essay Portion:

In your own words, please give us a personal statement and why you are pursuing a degree to become an Advanced Practice Provider.

What are you most proud of? Share an accomplishment you are proud of, either at school or in extracurriculars:

What are you hoping to gain out of this Internship experience? Explain your goals for the internship, the skills you want to learn, and how it will help you grow in your career:



CHECKLIST:

INTEGRIS Health Pre-APP Professional Development Internship Program

Checklist with supporting documentation must be submitted to Sarah Hufstedler, PA prior to the beginning of your Internship period. Please allow 4 weeks for processing time and 12 weeks for final selection. Please complete forms electronically and do not submit them until all are complete. Submitting forms individually will delay processing and **could result in the termination of your application.**

Upon completion, send all forms to: sarah.hufstedler@integrishealth.org

Required Documentation:

Documented proof of current university enrollment **OR** degree

Verification of the following immunizations:

A complete Hepatitis B vaccination series (series of 3 or waiver)

MMR vaccination(s) or positive titer(s)

This must include two doses of the mumps vaccine or positive mumps titers

A written verification of varicella history, varicella vaccination, or a varicella titer by a physician or a physician's designee

Written verification of the seasonal influenza vaccination and, at the request of the Facility, verification for other strains of influenza OR exemption form

Written verification of the COVID Vaccine complete series OR proof of exemption

IMPORTANT NOTE: If you are exempted from certain or all vaccines, you must submit your exemption form, regardless if currently enrolled in a university or not