



*Now Accepting Applications!*

**Post-Graduate Nurse Practitioner Residency in  
Community Health and Family Medicine**

Family Health Center of Worcester (FHCW) pioneered a Family Nurse Practitioner Residency in 2009, building upon the training resources of the Worcester Family Medicine Residency in collaboration with the UMass Chan Medical School. It quickly became clear that residency-prepared Nurse Practitioners have strong clinical practice and leadership abilities.

This 12-month, full-time residency provides new Family Nurse Practitioner (FNP) graduates with the foundation to build their career as a Primary Care Provider (PCP) in Community Health.

Residents will be full time employees and receive salary, support, and benefits.

The Post-Graduate Nurse Practitioner Residency in Family Practice and Community Health will:

- ❖ Prepare Family Nurse Practitioners to become comprehensive Primary Care Providers for complex underserved populations across the life span.
- ❖ Build upon the clinical knowledge acquired during formal education by providing clinical and professional support for Nurse Practitioners in an active learning environment.
- ❖ Expand the number of Nurse Practitioners interested in building a life-long career in community health.
- ❖ Prepare Nurse Practitioners for careers in organizations that provide care to underserved patient populations.

Residents work alongside preceptors and team members with a wide variety of expertise and clinical interests. Under the direct guidance of attending NPs, PAs, MDs, and DOs, Residents will have precepted continuity sessions where they see their own primary care patients. Residents will also have Shadow sessions, during which they will work alongside an experienced provider. Furthermore, Residents will have Specialty Sessions and may include areas such as reproductive health, addiction medicine, urgent care, procedure clinic, and telemedicine. Residents will

participate in weekly online Didactic Sessions.

Applicants will undergo a preliminary screening, and then be invited for onsite interviews. Applicants must meet all employment requirements of their individual site.

#### Application Requirements:

- ❖ Applicants must be within 18 months of graduation from their Nurse Practitioner program.
  - ❑ Applicants must agree to a full-time, 12-month residency and commit to a second year of full-time employment.
  - ❖ Applicants must be a citizen of the US or a foreign national with a visa permitting permanent residency in the US or a non-citizen national. Individuals on temporary or student visas are not eligible.
  - ❖ All applicants are required to have their MA Advanced Practice License, Federal DEA, and MA Controlled Substances Registration (MCSR) prior to starting clinical sessions.
    - ❖ *Please note*, preference will be given to applicants who have taken or scheduled their certification exam. Alternatively, if your Advanced Practice License is not available at the time of application, please submit a letter from your program stating that you are in good standing and expect to be eligible to test for national certification.
  - ❖ Complete the Residency Application and the Statement of Application and Release Form.
  - ❖ Provide the contact information of three references, at least one of which is clinical and one is a peer. This can include faculty.
  - ❖ Submit a narrative response to the following questions. This is an opportunity to reflect upon and communicate your personal qualifications, interest, and motivation for this residency. You may answer these as separate or combined questions. (Attach in Word or PDF; 12 pt font, 500-character limit.)
    - Reflect on a specific experience in your life (personal, professional, or educational) that demonstrates the path that led you to choose the role of Nurse Practitioner as a career.
    - Please comment on personal qualities that draw you to any or all of the following: Primary Care, Community Health, a Residency, Family Medicine.
    - If you have specific areas of interest (specialty or setting) that are essential for your happiness as a clinician, please share.
- \*\*\*Hint for all of the above: Show, don't tell; please answer with examples, not simply a list or description.
- ❖ Submit the following or provide a statement of the status (scanned documents are acceptable):
    - CV that clearly includes the following (no page or character limit):
      - Language ability, proficiency, and aspirations
      - NP clinical experiences including subjects, sites, and hours completed/expected to be completed
      - Registered Nurse experience and estimate of hours worked
      - Volunteer and leadership experience if applicable
    - Official Transcript
    - Copy of professional diploma (BSN, MSN)
    - Copy of RN and NP Massachusetts license
    - Board certification (ANCC/AANP) status
    - NPI number
  - ❖ Submit two letters of recommendation that specifically address the following:

- Letters should be addressed to the Post-Graduate NP Residency Selection Committee (attached in Word or PDF).
- Your relationship, and the capacity in which you have worked together.
- Assessment of your capabilities, both clinical and otherwise.
- Your interest as related to this Residency Program.
- The body of each letter should not exceed 250 words.

**This checklist will help you with the required materials  
to support your residency application.**

- Residency Application, including three (3) reference contacts
- Statement of Application and Release Form
- CV, as outlined previously
- Official Transcript
- Professional diploma (BSN, MSN)
- License as Registered Nurse (RN)
- APRN license, if available at time of application
- ANCC / AANP certification, anticipated date of testing, or evidence of eligibility for certification.

The letter from your school, on school letterhead, can state:

[Student name] is a student in good standing at [institution] in the Family Nurse Practitioner track and is expected to complete all academic and clinical requirements by [date] and be eligible to sit for the national certification exam.

- Federal DEA, MCSR, and MA license, if available at time of application.
- NPI number
- Residency essay, as outlined above
- Two letters of recommendation, as outlined above

**Application/inquiries/recruitment:**

Please submit your application to FHCW's Career Center:

<https://fhcw.org/join-our-team/>

The completed application must be received by **February 17<sup>th</sup>, 2025**. Selected individuals will be invited to interview on site **March 18<sup>th</sup> or March 19<sup>th</sup> 2025**, date subject to change.

Check this box only if you would like Family Health Center of Worcester to share your resume with other NP Residency programs or new graduate positions who they believe you may also be a good fit for (not required).

If you have questions, please contact Alyda Justiniano, Manager, Provider Relations/Credentialing at (508) 860- 7962 or email [Alyda.Justiniano@fhcw.org](mailto:Alyda.Justiniano@fhcw.org)

Mailing Address:

Alyda Justiniano, Manager, Provider Relations/Credentialing  
Attn: FNP Residency  
Family Health Center of Worcester  
26 Queen St.

Worcester, MA 01610

*Thank you for your interest in  
Post-Graduate Nurse Practitioner Residency in Family Practice and Community Health*

**Post-Graduate Nurse Practitioner  
Residency in Family Practice and Community Health  
Residency Application**

**ROTATIONS/FELLOWSHIPS/PRECEPTORSHIPS**

List in chronological order – include month/year of attendance and full mailing address of institution.

Institution \_\_\_\_\_  
Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Complete \_\_\_\_\_  
Address: \_\_\_\_\_  
Specialty \_\_\_\_\_  
Program Preceptor \_\_\_\_\_

Institution \_\_\_\_\_  
Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Complete \_\_\_\_\_  
Address: \_\_\_\_\_  
Specialty \_\_\_\_\_  
Program Preceptor \_\_\_\_\_

Institution \_\_\_\_\_  
Dates \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Complete \_\_\_\_\_  
Address: \_\_\_\_\_  
Specialty \_\_\_\_\_  
Program Preceptor \_\_\_\_\_

**PRACTICING SPECIALTY**

Primary Specialty: \_\_\_\_\_

Secondary Specialty: \_\_\_\_\_

**BOARD CERTIFICATION STATUS (if applicable)**

Certificate Year: \_\_\_\_\_

Last Year Recertification: \_\_\_\_\_

Field/Specialty: \_\_\_\_\_

Certifying Board/Number: \_\_\_\_\_

If not certified in one or more of your practicing specialties for which board certification is available, please complete the following, indicating the specialty(ies) to which your responses apply.

1. Have you been accepted by the Board to take the examination? YES \_\_\_ NO \_\_\_
2. Are you actively in the Board Certification Examination process? YES \_\_\_ NO \_\_\_  
If yes, indicate the year by which you must complete the process according to the Board's requirement \_\_\_\_\_

**OTHER CERTIFICATIONS/MEMBERSHIPS**

Indicate type or field in which certified (examples: BLS, ACLS, ATLS), date acquired, date expires, and organization issuing the certificate.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLINICAL REFERENCES**

Provide three (3) Clinical references with at least one being a clinical reference and one being a peer reference:

	<b>Reference #1</b>	<b>Reference #2</b>	<b>Reference #3</b>
<b>Name</b>			
<b>Relationship</b>			
<b>Institution</b>			
<b>Mailing Address</b>			
<b>City, State, Zip Code</b>			
<b>Email Address and Phone Number</b>			

**FEDERAL REPORTING COMPLIANCE:**

Birth year: \_\_\_\_\_

Gender: Optional, fill in the blank: \_\_\_\_\_  Decline to answer

Ethnicity:  Hispanic  Non-Hispanic  Decline to answer

Race:  African American/Black  
 American Indian or Alaskan Native  
 Asian  
 Native Hawaiian/Pacific Islander  
 White  
 Decline

Veteran/Current Military Service:  Yes  No  Decline

Did you grow up on a rural community?  Yes  No  Decline

Disadvantaged Status in response to the definition below:  Yes  No  Decline

*Do you come from an environment that has inhibited them from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions or nursing school (Environmentally Disadvantaged); AND/OR Comes from a family with an annual income below a level based on low-income thresholds established by the U.S. Census Bureau, adjusted annually for changes in the Consumer Price Index (Economically Disadvantaged). The Secretary defines a "low-income family" for various health professions and nursing programs included in Titles III, VII and VIII of the Public Health Service Act as having an annual income that does not exceed 200 percent of the Department's poverty guidelines. A family is a group of two or more individuals.*



**STATEMENT OF APPLICATION and RELEASE FORM**

(Please read carefully before signing.)

I understand that as the final step in acceptance to the residency, I must complete and satisfy the requirements of my future residency employer.

I also understand that my future residency employer is required to Privilege & Credential providers, therefore I agree to make available to my employer any documents or records, either in my possession or in the possession of another, which may have a material and reasonable bearing on my suitability as a contracted provider.

I hereby authorize any and all persons, institutions and organizations, including those specifically identified in this Application, with information pertaining to my professional standing or qualifications as a provider to furnish upon request, all such information to my employer, its employees and agents. In consideration for the furnishing by a person, institution or organization of information, I release the person, institution, or organization from and against any and all liability, loss, damage, claim or expense of any kind arising from or in connection with, disclosure of information to my employer made in good faith and without malice in conformance with this authorization.

I certify that the information provided herein, including attachments, represents full and truthful disclosures of the matters to which they pertain. A copy of this document shall be considered as valid as the original.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_