

2026-2027 Child Health Training Program Application

1. Last Name: *

2. First Name *

3. RN License # *

4. Highest Nursing Degree Earned *

- ADN
- BSN
- MSN
- Other

5. Agency Name: *

- Alamance County Health Department
- Albemarle Regional Health Services
- Alexander County Health Department
- Anson County Health Department
- Appalachian District Health Department
- Beaufort County Health Department
- Bladen County Health Department
- Brunswick County Health and Human Services
- Buncombe County Health and Human Services, Department of Health

Burke County Health Department
Cabarrus Health Alliance
Caldwell County Health Department
Carteret County Health Department
Caswell County Health Department
Catawba County Public Health
Chatham County Public Health Department
Cherokee County Health Department
Clay County Health Department
Cleveland County Health Department
Columbus County Health Department
Craven County Health Department
Cumberland County Health Department
Dare County Department of Health & Human Services — Public Health Division
Davidson County Health Department
Davie County Health Department
Duplin County Health Department
Durham County Department of Public Health
Edgecombe County Health Department, a Division of Edgecombe Human Services Agen
Forsyth County Department of Public Health
Franklin County Health Department
Gaston County Department of Health and Human Services — Public Health Division
Graham County Department of Public Health ♦
Granville-Vance District Health Department
Greene County Health Department
Guilford County Department of Health and Human Services – Division of Public Health
Halifax County Health Department
County of Harnett
Haywood County Health & Human Services Agency
Henderson County Department of Public Health
Hoke County Health Department
Hyde County Health Department
Iredell County Health Department
Jackson County Department of Public Health
Johnston County Public Health Department
Jones County Health Department
Lee County Health Department
Lenoir County Health Department
Lincoln County Health Department
Macon County Public Health
Madison County Health Department
Martin-Tyrrell-Washington District Health Department
Mecklenburg County Health Department
Montgomery County Health Department
Moore County Health Department
Nash County Health Department
New Hanover County Health Department
Northampton County Health Department
County of Onslow
Orange County Health Department
Pamlico County Health Department
Pender County Health Department
Person County Health Department

Pitt County Health Department
Randolph County Health Department
Richmond County Health and Human Services Department
Robeson County Department of Public Health
Rockingham County Department of Health and Human Services
Rowan County Health Department
Rutherford-Polk-McDowell District Health Department
Sampson County Health Department
Scotland County Health Department
Stanly County Health Department
Stokes County Health Department
Surry County Health and Nutrition Center
Swain County Health Department
Toe River Health District
Transylvania County Department of Public Health
Union County Consolidated Human Services Agency, Division of Public Health
Wake County Human Services
Warren County Health Department
Wayne County Health Department
Wilkes County Health Department
Wilson County Health Department
Yadkin County Human Services Agency

6. Health Department Address (line 1): *

7. Health Department Address (line 2): *

8. Education resources will be mailed directly to the student. Please provide your home mailing address.

Home Mailing Address (line 1) *

9. Home Mailing Address (line 2) *

10. Email Address: *

11. Phone Number - Direct work number (with extension if applicable) *

12. Cell Phone Number *

13. Type of Employment: *

- Full-time
- Part-time
- Contract service

14. Please document dates (from/to) for each of the specialty areas with which you have past or present experience (choose all that apply): *

Generalized

School Health

Child Health

Other (specify)

15. Indicate your nursing education date issued month/year (choose all that apply): *

Diploma

**Associates
Degree**

**Baccalaureate
Degree**

**Master's
Degree**

**Doctorate
Degree**

**Other (please
specify)**

16. Please indicate the date completed or the expected date of completion for the *North Carolina Credentialed Public Health Nursing Course* *

17. Preceptor Qualifications: The primary preceptor must be an advanced practice provider or physician. **It is strongly recommended that the provider have a specialty of Pediatrics or Family Medicine.** Secondary preceptor(s), if applicable, may be a rostered CH ERRN with a minimum of 2 years clinical practice. *See the 2026-2027 CHTP Local Planning Document for more details.* (Put NA for fields not applicable) *

Nurse Practioner	<input type="text"/>
Physician Assistant	<input type="text"/>
Physician	<input type="text"/>
CH ERRN (secondary preceptor only)	<input type="text"/>

18. Provide the following information on the primary preceptor and secondary preceptor (Put NA for fields not applicable): *

	Primary preceptor	Secondary preceptor (if applicable)
Name	<input type="text"/>	<input type="text"/>
Health Department Address	<input type="text"/>	<input type="text"/>
Phone	<input type="text"/>	<input type="text"/>
Email Address	<input type="text"/>	<input type="text"/>

19. Provide the following information on the Nursing Director and Clinical Supervisor (Put NA for fields not applicable): *

	Nursing Director	Clinical Supervisor
Name	<input type="text"/>	<input type="text"/>
Health Department Address	<input type="text"/>	<input type="text"/>
Office Phone	<input type="text"/>	<input type="text"/>
Cell Phone	<input type="text"/>	<input type="text"/>
Email Address	<input type="text"/>	<input type="text"/>

20. Provide the following information regarding the physician who will provide standing orders (if applicable): *

Medical Director who receives/approves nursing standing orders and provides ongoing consultation

Name	<input type="text"/>
Office Phone	<input type="text"/>
Email Address	<input type="text"/>

To be Completed by the Nurse Supervisor

21. Please describe your agency plan for the utilization of and support for this enhanced role nurse: *

22. How many CH ERRNs does your agency currently have on staff? *

23. If your agency does not currently have any CH ERRNs on staff, has the agency previously had CH ERRNs on site in the past? If so, how long has it been since your agency has had a CH ERRN on staff? (If you currently have a CH ERRN put NA) *

24. Does the agency have other rostered enhanced role nurses, i.e., STD ERRNs? (Please specify) *

25. What Child Health services does your agency provide? (select all that apply): *

- Preventative visits only
- Both preventative and sick visits
- Newborn Home Visits
- Behavioral health services
- Medical Nutrition Therapy services,
- Adolescent Reproductive Health services
- Other child health clinical services (i.e. orthopedic clinic, etc.)

26. What access will the CH ERRN have for medical consultation?*

- Onsite medical consultation
- Medical consultation via phone
- Both

27. What electronic health record does your agency use?

28. What sources are you using for age specific anticipatory guidance and education? *

Signatures


29. Applicant Signature: *

Clear

Sign name using mouse or touch pad

Signature of

30. Date of Applicant Signature: *

Region & Consultant

31. Click here for Regional Child Health Nurse consultant map *

- Region 1-Amanda Lambert
- Region 2-Robin Wallin
- Region 3-Brenda Sedberry
- Region 4-Angie Moody
- Region 5-Lynette Robinson