**\*\*This form is to be completed by the graduate student before field work begins\*\***

**University of Florida**

**Master of Health Science**

**One Health Field Research Experience**

**Student One Health Field Research**

**Proposal Form**

Directions: Please complete the ENTIRE application form before submitting. Incomplete or hand-written applications will be automatically returned to the student.

### STUDENT INFORMATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UFID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address *during field research experience:*

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

Street Apt. # City State Zip

Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### FIELD RESEARCH INFORMATION

Expected number of course credits (1 credit=48 course effort hours; 3 credits required 5 credits max): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Semester/year desired: Final report due date: 4 weeks after completion of field research

Project title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My field research experience is located in a rural area YES NO

My field research experience impacts rural populations(s) YES NO

Do you have reliable transportation? YES NO

Do you have any disabilities that might hinder your performance during your project? YES NO

If YES, please explain

Does this site require a formal contract to be signed prior to beginning the field research experience?

YES NO

Are you required to have insurance as result of participation in this project? YES NO

If YES, please check all that apply:

Personal accident insurance Personal liability insurance Health insurance

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRECEPTOR/AGENCY INFORMATION**

**Please include a copy of the preceptor’s resume or CV**

Organization/agency name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preceptor’s name, credentials and position title:

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Suite/room # City State Zip

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### FIELD RESEARCH EXPERIENCE WORKPLAN

Attach a detailed work plan that includes the items below. The work plan must summarize the field research experience and what role you as a student will play and provide sufficient information to determine whether the project can be completed in the time allotted.

* *Field research experience organization/agency* — the purpose, mission or goals of the organization and the population(s) they serve, especially the organization’s public health programs or projects.
* *Student’s goals and objectives* — include learning objectives for all projects and activities you will be working on during your internship/practicum. Identify the objectives for your special project clearly
* *Competencies*- identify the specific MSH and concentration-specific competencies you will strengthen during your internship (see student evaluation form)
* *Significance* — Describe why your field research experience and special project are significant to public health
* *Methods* — describe the research methods (planned for the project) you will use to carry out your project(s).
* *Timeline* — include a timeline for completion of each project or activity, with particular attention to your roles. If a particular assignment or activity will be ongoing, please so indicate. Be as specific as possible.
* *Role of participating parties* — describe the roles of your preceptor and teammates (if applicable).

**IRB APPROVAL**

Will you be collecting data from human subjects? YES NO

Is IRB approval necessary? YES NO Obtained? YES NO

If not yet obtained, please explain and specify your timeline for acquiring approval:

Are other approvals necessary? YES NO

 If YES, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Obtained? YES NO

**Field research experience at current place of employment (only complete this section if appropriate)**

I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student name) will be conducting an internship in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (department or program) at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (organization name) while maintaining employment in the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (department or program).

### During the course of the field research experience, the student will undertake duties and responsibilities that are different from current duties and responsibilities. Hours related to current responsibilities cannot be counted toward internship hours; neither can internship hours count as regular work hours.

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

**Employer signature and Date**

### SIGNATURES

By signing below, the participating parties indicate that they have read and approved the student’s F.R.E project work plan/proposal.

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

Student signature and date Agency preceptor signature and date

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

Faculty advisor signature and date Academic program coordinator signature and date

Please return this completed form to HPNP 4160 or email your Academic Coordinator.