My Care Clinic (MCC) LLC,
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My Care Clinic LLC – The Pathway for Recovery

Preceptorship & Behavioral Health Practice Setup Intake Form

Thank you for your interest in partnering with My Care Clinic LLC. We are committed to empowering future and current behavioral health professionals through education, mentorship, and business development. Please complete the form below so our team can better understand your needs and goals.

Section 1: Personal Information

Full Name: _____

Email Address: _____

Phone Number: _____

Preferred Contact Method: ☐ Email ☐ Phone ☐ Text

Current City/State: _____

Section 2: Program Interest

☐ PMHNP / NP Preceptorship Program

☐ Behavioral Health Practice Startup Consultation

☐ OMHC or PRP Program Setup (coming soon)

☐ Business Mentorship / Coaching

☐ Quality Assurance or Policy Development (Coming Soon)

☐ Other: _____

Section 3: Professional Background

Current Role/Title: _____

Highest Level of Education:

_____

School / Institution (if applicable):

_____

Expected Graduation Date (for students):

_____

Professional License Type (if applicable): ☐ RN ☐ NP ☐ LCSW-C ☐ LCPC ☐ Other: _____

License Number / State: _____

Are you currently affiliated with a behavioral health organization? ☐ Yes ☐ No

If yes, please list the organization name:

_____

Section 4: Goals & Interests

What are your goals for joining the program?

_____

_____

_____

_____

Areas of Focus (check all that apply):

☐ Psychiatric Assessment & Documentation

☐ Medication Management

☐ Therapy & Counseling Skills

☐ Clinical Workflow / EHR Training

☐ Business Licensing & Compliance (coming soon)

☐ Marketing & Branding

☐ Policy & Procedure Development (coming soon)

☐ Staff Training / Quality Improvement (coming soon)

Section 5: Availability

Preferred Start Date: _____

Availability: ☐ Weekdays ☐ Weekends ☐ Evenings ☐ Flexible

Preferred Learning Format: ☐ Virtual ☐ In-person ☐ Hybrid

Section 6: Additional Information

How did you hear about My Care Clinic? ☐ Website ☐ Referral ☐ Social Media ☐ Email ☐ Other: _____

Please describe any special requests or accommodations:

_____

_____

Section 7: Consent & Agreement

By submitting this form, I acknowledge that:

- Submission does not guarantee placement or acceptance.

- My Care Clinic LLC reserves the right to review applications based on program availability and eligibility.

- I consent to be contacted by a representative from My Care Clinic LLC regarding next steps.

Signature : _____ Full Name: _____

Date: _____