

# [First Last, MSN, APRN, FNP-C]

[City, State] | [email@example.com] | [(555) 555-5555] | [LinkedIn URL]

## PROFESSIONAL SUMMARY

[Board-certified **Nurse Practitioner** with [X] years of advanced practice experience] in [primary care/acute care/specialty setting]. Skilled in **comprehensive patient assessment**, evidence-based treatment planning, and chronic disease management across diverse populations.

Proven ability to **optimize clinical workflows**, collaborate within interdisciplinary teams, and deliver patient-centered care that improves outcomes and satisfaction scores. Experienced with [EMR/EHR systems], care coordination, and patient education for [adult/geriatric/pediatric] populations.

## PROFESSIONAL EXPERIENCE

### [Family Nurse Practitioner] | [Community Health Clinic Name]

[Month Year] – Present | [City, State]

- Conduct [X–Y] comprehensive patient assessments per day, including history, physical exams, diagnosis, and treatment for acute and chronic conditions, following evidence-based guidelines and clinic protocols.
- Manage a panel of approximately [###] patients with chronic diseases (e.g., [diabetes, hypertension, COPD]), resulting in [X% improvement] in key quality metrics such as [A1c control, blood pressure targets, medication adherence].
- Utilize [EHR System Name] to document encounters, order labs/imaging, e-prescribe medications, and coordinate referrals, improving documentation completeness and reducing charting time per visit by [X%].

### [Acute Care Nurse Practitioner] | [Regional Medical Center Name]

[Month Year] – [Month Year] | [City, State]

- Delivered advanced practice care in [hospital unit/step-down/ED], performing focused assessments, formulating differential diagnoses, and initiating treatment plans under collaborative practice agreements with attending physicians.
- Led daily interdisciplinary rounds with [physicians, RNs, pharmacists, case managers], streamlining care plans and contributing to a [X% reduction] in average length of stay for assigned patient population.
- Performed and interpreted common diagnostic procedures (e.g., [EKGs, point-of-care testing, wound assessments]) and provided timely updates to patients and families, improving patient satisfaction scores in communication domains.

## EDUCATION

### [Master of Science in Nursing (MSN), Family Nurse Practitioner] | [University Name]

[Month Year] – [Month Year] | [City, State]

[GPA: X.XX/4.0 (if applicable)] | Relevant Coursework: [Advanced Pathophysiology, Advanced Pharmacology, Advanced Health Assessment, Primary Care of Adults & Families]

### [Bachelor of Science in Nursing (BSN)] | [University Name]

[Month Year] – [Month Year] | [City, State]

[Honors/Dean's List if applicable] | Clinical Rotations: [Medical-Surgical, Pediatrics, Obstetrics, Mental Health, Community Health]

## SKILLS

**Clinical:** [Comprehensive patient assessment], [Diagnosis & treatment planning], [Chronic disease management], [Preventive care & wellness counseling], [Minor procedures (e.g., suturing, I&D, wound care)], [Ordering & interpreting labs/diagnostics]

**Technical:** [EHR/EMR systems (e.g., Epic, Cerner, Athenahealth)], [e-Prescribing platforms], [Telehealth platforms], [Clinical decision support tools], [Microsoft Office (Word, Excel, PowerPoint)]

**Regulatory & Quality:** [Evidence-based practice], [Clinical documentation standards], [HIPAA compliance], [Quality improvement initiatives], [Population health management]

**Interpersonal:** [Patient education & counseling], [Interdisciplinary collaboration], [Cultural competence], [Conflict resolution], [Time management], [Leadership & precepting]

## PROJECTS & CLINICAL INITIATIVES

**[Chronic Disease Management Optimization Project] | [Community Health Clinic Name]**

[Month Year] – [Month Year]

- Designed and implemented a standardized follow-up protocol for patients with [type 2 diabetes and hypertension], incorporating patient education materials, medication reconciliation, and scheduled telehealth check-ins.
- Collaborated with nursing and care coordination teams to create a registry in [EHR System Name], enabling proactive outreach to high-risk patients and improving appointment adherence by [X%].

**[Telehealth Primary Care Expansion Initiative] | [Healthcare Organization Name]**

[Month Year] – [Month Year]

- Participated in development and pilot of telehealth visit workflows for [adult primary care patients], including triage criteria, documentation templates, and patient education on virtual visit preparation.
- Conducted [X] telehealth visits per week using [Telehealth Platform Name], maintaining high patient satisfaction and ensuring continuity of care during periods of limited in-person access.