INTERNSHIP APPLICATION

Name _____
Address _____
City _____ State _____ Zip Code _____
E-mail _____ Phone _____
Emergency Contact Name: _____
Emergency Contact Phone _____
School _____ Year in School _____

Why do you want to pursue a healthcare internship at The Community Health Clinic? (Please provide a 3-5 sentence explanation)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Are you enrolled in or have you taken any of the following classes? *(check all that apply)*

_____ Anatomy and Physiology
_____ Advanced Biology
_____ Health Occupations
_____ LPN
_____ Advanced Chemistry
_____ CPR
_____ CAN
_____ RN
_____ Other Health Care Preparatory Class (please list) _____
_____
_____

How many internship hours are you requesting? _____

Please list your expected start and end date:
Beginning Date: _____ End Date:_____

Please list two instructors who can be contacted as a reference:
Name:_____ Phone:_____
Position _____
Name:_____ Phone:_____
Position _____

Signatures:
To be part of The Community Health Clinic Internship Program, I understand that all participants will abide by our Confidentiality Policy.

Student's Signature _____ Date _____

Operations Director, CHC Signature _____ Date _____

Once you have been accepted, you must provide information from your program. Criteria for internship and any paperwork that must be filled out by the Operations Director or Clinical staff is the responsibility of the student. During orientation you will be given information regarding confidentiality, safety, the mission of the organization, Patient's Rights, attendance expectations and dress code

Return this application to Sharon Chupp, Clinical Supervisor
The Community Health Clinic
315 Lehman Ave., Suite C
Topeka, IN 46571
Ph: 260-593-0108
Fax: 260-593-0116

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