Whitney Young Health
Non-Clinical Internship Application

Contact Information

Full Name _____

Street Address _____

City, State and Zip Code _____

Phone Number _____

E-Mail Address _____

School & Program Affiliation

School _____

Degree _____

Desired Semester ☐ Fall Semester ☐ Spring Semester ☐ Summer Semester

Desired Department ☐ Marketing/Development ☐ IT ☐ Finance

☐ Human Resources ☐ Dental Shadowing

Internship Hours ☐ I do not have required hours ☐ I have hour requirement: _____

Availability

Internship Start Date _____ **Internship End Date** _____

Monday ☐ I am available Hours available _____

Tuesday ☐ I am available Hours available _____

Wednesday ☐ I am available Hours available _____

Thursday ☐ I am available Hours available _____

Friday ☐ I am available Hours available _____

Applicant Details

What internships or volunteer opportunities have you completed prior to this experience, in your field. Please include name of location, specialty, start date of opportunity, & opportunity length.

Why do you wish to complete an internship at Whitney Young Health?

Applicant Affirmation

For an internship at Whitney Young Health, additional screening is required prior to start date. If a placement is offered you agree to complete all screening including but not limited to proof of physical exam, proof of negative Tuberculosis, proof of Measles, Mumps, & Rubella vaccinations, and background check(s). I agree to complete these contingencies prior to my start or forfeit my placement.

Initials

I agree to attach my resume or CV to my application for review

Initials

I agree that the information provided is true and accurate.

Name

Signature

Date