



Williamson County and Cities Health District

Date received by WCCHD: \_\_\_\_\_

# Internship Program Application

Student name: \_\_\_\_\_

Contact phone: \_\_\_\_\_ Contact e-mail: \_\_\_\_\_

School: \_\_\_\_\_

Highest level of education completed: \_\_\_\_\_

Which semester are you requesting hours? \_\_\_\_\_

Number of hours needed: \_\_\_\_\_

Days/times available:

- Monday from \_\_\_\_\_ to \_\_\_\_\_
- Tuesday from \_\_\_\_\_ to \_\_\_\_\_
- Wednesday from \_\_\_\_\_ to \_\_\_\_\_
- Thursday from \_\_\_\_\_ to \_\_\_\_\_
- Friday from \_\_\_\_\_ to \_\_\_\_\_

Dates available:  
 Start: \_\_\_\_\_ to  
 Start: \_\_\_\_\_

Please select your preferred areas of interest:

- Clerical
- Community Outreach
- Emergency Response
- Employee Wellness
- Epidemiology
- Health Education
- Marketing
- Mosquitoes/Arbovirus
- Nutrition
- Tobacco Use Prevention
- Other \_\_\_\_\_

Type of experience needed/wanted:

Preceptor required:  Yes  No

The student/school should present WCCHD with proof that students have:

- 1) Background check
- 2) Full immunization recording including Hepatitis B
- 3) Proof of TB skin test within the last year

### WCCHD STAFF USE ONLY

School agreement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Signed Code of Ethics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Required items received	<input type="checkbox"/> Yes <input type="checkbox"/> No	Signed Statement of Confidentiality	<input type="checkbox"/> Yes <input type="checkbox"/> No
Student scheduled	<input type="checkbox"/> Yes <input type="checkbox"/> No		

If YES, program/dates/times: \_\_\_\_\_  
 If NO; why not? \_\_\_\_\_

Completed assignment  Yes  No If not, why? \_\_\_\_\_  
 Assigned to: \_\_\_\_\_  
 Evaluation completed:  Yes  No Evaluator Signature: \_\_\_\_\_



## Williamson County and Cities Health District

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### Internship Program Participation Acknowledgement

#### NO GUARANTEED PLACEMENT STATEMENT

I hereby understand that my participation in the Williamson County and Cities Health District Internship Program (WCCHD) is voluntary and I am not obligated by this statement to remain in the Program for a specified period of time. I, furthermore, understand that I am not guaranteed an internship placement. By signing this statement, I acknowledge that I am participating in the Program with full knowledge that there are only a limited number of internships available – the number of students seeking internships may limit a student's placement potential.

Student Name (please print): \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_