# APPLICATION FOR CLINCAL INTERNSHIP

An Equal Opportunity Employer - All qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, disability status, protected veteran status, or any other characteristic protected by law.

## PERSONAL INFORMATION

*Please complete all fields. Incomplete information could disqualify you from further consideration.*

Application Date___________________ Internship position desired _______________________________________

Name (First, Middle, Last) ________________________________________________________________________

Maiden/Alternate Name___________________________________________________________________________

Address ______________________________________________________________________________________

E-mail Address ______________________________ DOB ________________ SS # _________________________

Home Phone # _________________________________ Mobile Phone # __________________________________

Are you at least 18 years or older? (If no, you may be required to provide authorization to work.) □ Yes □ No

Are you able to perform the essential functions of the internship for which you are applying, with or without a reasonable accommodation? □ Yes □ No

Have you ever been convicted of a felony? □ Yes □ No Explain: __________________________________________

Have you ever been convicted of a violent crime? □ Yes □ No Explain: _____________________________________

Have you ever served in the United States armed forces? □ Yes □ No

Are you a member of a National Guard or Reserve organization? □ Yes □ No

MCWC disallows internship of former clients who have received services within the 12 months prior to the date of this application. Have you received any services from MCWC during this period? □ Yes □ No Explain:

______________________________________________________________________________________________

Have you ever been employed by this organization before? □ Yes □ No If yes, what position? ___________________

Have you ever been an intern for this organization before? □ Yes □ No

If you are obtaining an internship through school, what school are you attending? ____________________________

What licenses do you have? _______________________________________________________________________

What level of education do you have? ☐ Pre-graduate ☐ Graduate ☐ Post-graduate What year? _______________

## REFERRAL SOURCE:

Do you know anyone who works or volunteers for our company? □ Yes □ No  If yes, who? _____________________

How did you hear about our internship program? (Please check all that apply)

☐ Newspaper ☐ Radio ☐ Television ☐ Speaker from MCWC ☐ School ☐ Online: What website? _______________

## EDUCATION:

Name & Location of School (High School) ____________________________________________________________

No. of Years Attended ______ Degree Rec'd __________________________________________________________

Name & Location of School (Pre-graduate) ___________________________________________________________

No. of Years Attended ______ Degree Rec'd _________________ Subjects Studied/Major ___________________

Name & Location of School (Graduate) ______________________________________________________________

No. of Years Attended ______ Degree Rec'd _________________ Subjects Studied/Major ___________________

Name & Location of School (Post-graduate) _________________________________________________________

No. of Years Attended ______ Degree Rec'd _________________ Subjects Studied/Major ___________________

## EMERGENCY INFORMATION

Submission of this information and form is voluntary for all MCWC volunteers/interns. This form is intended only as a source of information in the event of a life-threatening illness or injury.

Name (First, Middle, Last) __________________________________________________ DOB__________________

Address __________________________________________________________________________________________

Emergency Contact: ________________________________________________________________________________

Emergency contact phone number: ___________________________________________________________________

Emergency contact relationship to you: ______________________________________________________________

Name of physician: ________________________________Phone: __________________________________________

Choice of hospital: ________________________________ Phone: __________________________________________

List any existing medical conditions (diabetes, hypertension, etc.):

__________________________________________________________________________________________________

__________________________________________________________________________________________________

List all allergies to foods, medications, etc. and describe symptoms of reactions:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

List all medications taken regularly:

__________________________________________________________________________________________________

__________________________________________________________________________________________________

Do you wear contact lenses? ☐Hard ☐Soft ☐ No

I give the Montgomery County Women's Center permission to release the above information to appropriate personnel in the event of an accident or medical emergency.

_____________________________________ _______________________________________

Signature Date

## Montgomery County Women's Center

## FCRA Authorization to Obtain a Consumer Report (Background/Credit Check)

Pursuant to the federal Fair Credit Reporting Act, I hereby authorize Montgomery County Women's Center and its designated agents and representatives to conduct a comprehensive review of my background through a consumer report and/or an investigative consumer report to be generated for employment, internship, promotion, reassignment or retention as an employee. I understand that the scope of the consumer report/investigative consumer report may include, but is not limited to, the following areas: verification of Social Security number; current and previous residences; employment history, including all personnel files; education; references; credit history and reports; criminal history, including records from any criminal justice agency in any or all federal, state or county jurisdictions; birth records; motor vehicle records, including traffic citations and registration; and any other public records.

I, ______________________________, authorize the complete release of these records or data pertaining to me that an individual, company, firm, corporation or public agency may have. I hereby authorize and request any present or former employer, school, police department, financial institution or other persons having personal knowledge of me to furnish Montgomery County Women's Center or its designated agents with any and all information in their possession regarding me in connection with an application of employment. I am authorizing that a photocopy of this authorization be accepted with the same authority as the original.

I understand that, pursuant to the federal Fair Credit Reporting Act, if any adverse action is to be taken based upon the consumer report, a copy of the report and a summary of the consumer's rights will be provided to me.

______________________________________ ______________________________

Signature Date

______________________________________

Printed Name (First, Middle, Last)

*For office use only:*

Background check completed (date): ______________________ *attach copy to application

Confidentiality: __________________ Home-Study: ___________________ OAG: _________________

Volunteer training: __________________ Volunteer Type: ____________________________________

Completed by: ________________________________________________________________

Name & title: _________________________________________________________________

Comments: ___________________________________________________________________