

**Envision Wellness WNY
STUDENT INTERN APPLICATION**

 FULL NAME ()
TELEPHONE NUMBER

 DATE OF BIRTH SOCIAL SECURITY # EMAIL ADDRESS

 STREET ADDRESS CITY STATE ZIP CODE

 EMERGENCY CONTACT RELATIONSHIP ()
 TELEPHONE NUMBER

 STREET ADDRESS CITY STATE ZIP CODE

 STREET ADDRESS CITY STATE ZIP CODE

 SCHOOL CURRENTLY ATTENDING ADDRESS

 DEGREE & MAJOR? EXPECTED COMPLETION DATE?

IS THIS INTERNSHIP A SCHOOL REQUIREMENT? Yes No

 LIAISON NAME ()
 TELEPHONE

WHAT DO YOU HOPE TO LEARN FROM THIS INTERNSHIP?

SEMESTER(S) REQUESTED ___ Fall ___ Spring ___ Summer YEAR _____

AVAILABILITY?

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
FROM					
TO					

 DATE AVAILABLE TO START DATE INTERNSHIP MUST BE COMPLETED
 Date: ____/____/____ Date ____/____/____

LANGUAGES IN WHICH YOU ARE FLUENT?

RELEVANT EXPERIENCE

Supervisor: _____
 Director: _____ Program: _____

HR Only	
Internship Start Date _____	Fingerprints Completed _____(Date) _____(HR Initial)
Internship End Date _____	Taken out of Justice Center _____(Date) _____(HR Initial)

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CONFIDENTIALITY AND CORPORATE COMPLIANCE AGREEMENT

I understand and agree that in accordance with applicable state and federal law, all client records are to be kept confidential. No records or information relating to any client, including names, addresses, histories, or other identifying information, may be disclosed to an outside source in any manner without written consent of the client.

I further understand that it is my responsibility to safeguard information in my control. I can not discuss confidential information that may be overheard by clients and /or other individuals who should not have access to such information.

I understand that any breach of confidentiality could result in termination of the internship.

Signature _____

Date _____