THERAPEUTIC RECREATION INTERNSHIP APPLICATION HILLVIEW HEALTH CARE CENTER

Name	Date:				
(Last)	(First)				
Present address:					
	(Street)				
	(City, State, Zipcode)				
Iome Phone:					
Cell Phone:					
E-mail address:					
Emergency Contact (name and phone	number):				
Relationship:					
References: (Only one may be a profe	essor)				
· (Nome)					
(Name)	(Name)				
(Relationship to you)	(Relationship to you)				
()	()				
(Day-time phone number)	(Day-time phone number)				
(e-mail address)	(e-mail address)				
(Name)	_				
(Ivaine)					
(Relationship to you)	_				
(Day-time phone number)					
	_				
(e-mail address)					
Degree:					
Minor:					
Graduate Student? (yes or no)					

CONTINUED ON BACK

Semester and year of desired internship:
What are your plans after the internship is completed?

Are you able to complete your internship during the hours of? 8:00 am – 4:30 pm Monday – Friday?
(Yes/No)
11: 00 am– 7:30 pm one night a week?(Yes/No)
7:00 am– 3:30 pm on a Saturday at least 3 times?
(Yes/No)
What special skills, hobbies, or previous experiences are you able to share?
Any physical limitations: Yes No If yes, please explain:
Is it OK to take pictures of you for bulletin boards, newsletters, etc?YesNo

Hillview does not accept any person involved in theft, abuse, or drug cases.
INTERNS WILL HAVE A CAREGIVERS BACKGROUND CHECK COMPLETED

Signature:			