HALIFAX HEALTH

Student Internship Application – General

Student Contact

First name: Last name:

Phone number: Email:

Student Physical Address

Address Line 1:

Address Line 2:

State: City: ZIP:

School Contact

College / University:

City: State:

Program or Area of Study:

List your school or program title (School of Nursing Medical Assistant).

Program of study's EAA Code:

Is your program accredited: ☐ **Yes** ☐ **No**

If program is accredited: What is the name of the accrediting agency?

(e.g. Accreditation Council for Pharmacy Education; Accrediting Bureau of Health Education Schools)

First name:

First name of your program coordinator.

Last name:

Last name of your program coordinator.

Phone number:

List the telephone contact of your program coordinator.

Email:

List the e-mail contact of your program coordinator.

Tell us about you

Degree Level: ☐ **Certificate or Diploma** ☐ **Associate's Degree**

☐ **Bachelor's Degree** ☐ **Master's Degree** ☐ **Doctorate Degree**

Expected Graduation: Year Month

What is your current GPA?

Do you currently work for Halifax Health? ☐ **Yes** ☐ **No**

If so, what is your employee ID number?

Desired type of position/department placement

Why should we consider you for placement at Halifax Health?

Please limit your entry to 500 characters.

Student Internship

Desired start of internship? Desired end of internship?

How did you hear about us?

Who referred you to the Halifax Health Student Internship website?

☐ **School Advisor** ☐ **Halifax Health Team Member** ☐ **Prior Student**

☐ **Website** ☐ **Halifax Health Office of Student Placement**

If applicable, provide the name of Halifax Health Team Member who you have had communications with regarding a potential internship: