Community Healthlink
A Member of UMass Memorial Health Care

APPLICATION FOR INTERNSHIP

Date _____

TYPE OF INTERNSHIP (Check all that apply) ☐ **Undergraduate** ☐ **Graduate**

☐ In-clinic ☐ Home-based ☐ School-based ☐ Residential ☐ Nursing ☐ Adults ☐ Adolescents ☐ Children

☐ Other: _____

PERSONAL

Last Name	First Name	Middle Initial	Maiden Name (If applicable)	
Address (Number & Street, Apartment or Box No.)		City	State	Zip
Home Phone	Work Phone	Cell/Mobile Phone	Best Way to Contact	
E-mail Address				

Have you ever been previously employed by Community Healthlink? ☐ Yes ☐ No	If yes, list dates employed:	
	From: To:	Program(s):

EDUCATION

School/Institution (City, State)	Did you Graduate?	Major/Area of Study	Level	Degree / Date of Graduation
1. **High School** Name: _____ City, State: _____ Contact Name: _____ Phone No: _____	☐ Yes ☐ No ☐ Currently Enrolled		☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior	Degree: Date of Graduation:
2**. College/University** Name: _____ City, State: _____ Contact Name: _____ Phone No: _____	☐ Yes ☐ No ☐ Currently Enrolled		☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Grad Student	Degree: Date of Graduation:
3. **Other (Graduate/Trade School)** Name: _____ City, State: _____ Contact Name: _____ Phone No: _____	☐ Yes ☐ No ☐ Currently Enrolled			Degree: Date of Graduation:

AVAILABILITY

Please check semesters of availability and provide dates required for the internship:

☐ Fall _____ ☐ Spring _____ ☐ Summer _____ ☐Other, please explain:_____

Please check your general availability (*if unavailable please leave day blank*)

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Morning (Approx. 9 – 1)	☐	☐	☐	☐	☐	☐	☐
Afternoon (Approx. 1 – 5)	☐	☐	☐	☐	☐	☐	☐
Evening (Approx. 5 – 9)	☐	☐	☐	☐	☐	☐	☐

WORK/VOLUNTEERING EXPERIENCE (Please attach a copy of your resume)

Are you currently employed? ☐ Yes ☐ No

If yes, may we contact your present employer? ☐ Yes ☐ No

Begin with present or most recent employer and list prior employers. You may include any verifiable work performed on a voluntary basis.

1. Name of Employer		Address		City	State	Zip Code
Dates Employed		Salary		☐Full-Time ☐Intern/Volunteer ☐Part-Time ☐Temporary		Your Job Title:
From:	To:	Start:	End:			
Phone:		Supervisor's Name:			Supervisor's Title:	
Describe Major Duties:					Reason For Leaving:	

2. Name of Employer		Address		City	State	Zip Code
Dates Employed		Salary		☐Full-Time ☐Intern/Volunteer ☐Part-Time ☐Temporary		Your Job Title:
From:	To:	Start:	End:			
Phone:		Supervisor's Name:			Supervisor's Title:	
Describe Major Duties:					Reason For Leaving:	

3. Name of Employer		Address		City	State	Zip Code
Dates Employed		Salary		☐Full-Time ☐Intern/Volunteer ☐Part-Time ☐Temporary		Your Job Title:
From:	To:	Start:	End:			
Phone:		Supervisor's Name:			Supervisor's Name:	
Describe Major Duties:					Reason For Leaving:	

FOREIGN LANGUAGE PROFICIENCY	**LEVEL OF PROFICIENCY**

	ORAL				WRITTEN			
	Fluent	Good	Fair	N/A	Fluent	Good	Fair	N/A
SPANISH	☐	☐	☐	☐	☐	☐	☐	☐
PORTUGESE	☐	☐	☐	☐	☐	☐	☐	☐
VIETNAMESE	☐	☐	☐	☐	☐	☐	☐	☐
MANDARIN	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please indicate)	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

PLEASE ANSWER THE FOLLOWING QUESTIONS: (Use an additional sheet if necessary)

1. Please describe your knowledge of Community Healthlink (CHL) and the services we offer. What interests you most about an internship with CHL?

2. Please expand upon your career goals and why you would benefit from an internship at CHL?

3. What aspects of Mental Health Services most interest you and why?

COURSE CREDIT INFORMATION

Summary of Practicum Hrs	**Doctoral**	**Terminal Masters**	**Total Completed**
a. Total Intervention Hrs needed: _____ Includes adult or children individual hours, group counseling hours and intakes conducted.			
b. Total Supervision Hrs needed: _____			
c. Specify Supervisory Certification, Licensure or Degree Requirements: _____			
Grand Totals			

OTHER COURSE RELATED REQUIREMENTS: (Use an additional sheet if necessary)

COURSE CREDIT: Community Healthlink (CHL) will support students who have a specific research topic they wish to develop to earn college credit. However, the topic must be preapproved by CHL in advance of starting the internship/volunteering. **The specific criteria necessary to earn credit will also need to be coordinated between CHL and the school involved**. Please provide the criteria and list a school contact in the space provided on the application (you may provide an attachment from your school as well).

ELIGIBILITY: A candidate must be a graduate student; an undergraduate student; have graduated from high school or attained a GED diploma within 6 months of beginning the internship. It is recommended that the applicant have a degree or entering into a major or minor in Human Services (or related subjects).

SCHEDULE: Interns will work with CHL to arrange for a flexible work schedule. Interns are expected to work according to their agreed upon schedule; failure to do so without prior notification will likely result in termination of the internship.

DISMISSAL: Interns are expected to dress and conduct themselves in a professional fashion that is appropriate to the program. Interns must utilize their time effectively; involvement in their respective program(s) is encouraged however unnecessary distractions will not be tolerated. If standards are not met, this may be grounds for termination of the internship.

REFERENCES

Name	Current Company	Relationship	Phone	E-mail

*** WE ARE AN EQUAL OPPORTUNITY AFFIRMATIVE ACTION EMPLOYER AND DO NOT DISCRIMINATE AGAINST ANY PERSON ON THE BASIS OFRACE RELIGION, , COLOR, NATIONAL ORIGIN, GENDER, AGE, , VETERAN STATUS, SEXUAL ORIENTATION, DISABILITY OR ANY OTHER CATEGORY PROTECTED BY LAW.**

It is unlawful in Massachusetts to require or administer a lie detector test as a condition of employment or continued employment. An employer who violates this law shall be subject to criminal penalties and civil liability.

I certify that all the information that I have provided on this application is true and complete to the best of my knowledge. Any misrepresentation or omission of any fact in my application, resume, or other materials, or during interviews, can be justification for refusal of internship, or, if employed, termination from employment.

I authorize and request that all of my present and former employers and those individuals I have listed as personal references furnish information about my employment record, including a statement of the reason for the termination of my employment, work performance, abilities, and other qualities pertinent to my qualifications for internship. I hereby release my present and former employers, those individuals I have listed as personal references and Community Healthlink from any and all liability for damages arising from furnishing the requested information. I understand that if I refuse to provide such authorization, my application for internship will not be considered.

I understand that this Application for Internship is not an offer of employment. I understand that nothing contained in this internship application creates a contract between Community Healthlink and myself for employment or any other benefit. No promises regarding an internship have been made and I understand that no such promise or guarantee is binding upon Community Healthlink. I understand that if my internship application is accepted, either I or Community Healthlink can terminate my internship at any time for any or no reason.

My typed name below shall have the same force and effect as my written signature.

_____ _____

Signature of Applicant Date

CORI REQUEST FORM

COMMUNITY HEALTHLINK has been certified by the Criminal History Systems Board for access to all conviction and pending criminal case data.

As an applicant/employee for the positions of _____
I understand that a record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. I further understand and agree that periodic checks maybe conducted during my employment at Community Healthlink, Inc. The information below is correct to the best of my knowledge.

_____ _____
Applicant / Employee Signature (Unless otherwise preempted by law) Date

APPLICANT/EMPLOYEE INFORMATION (PLEASE PRINT)

_____ _____ _____
Last Name First Name Middle Name

_____ _____
Maiden Name or Alias (if applicable) Place of Birth

_____ ___ - ___ - ___ _____
Date of Birth Social Security Number (Last six digits required) ID Theft Index PIN (If applicable)

_____
Mother's Maiden Name

Current And Former Addresses:

_____

_____

Gender: ☐ Female ☐ Male Height: ft. in. Weight: ____ Eye Color: _____

State Driver's License #: _____ State of Issue: _____

*** The Above Information was verified by reviewing the following form of Government Issued Photographic Identification: _____.

Requested by: _____
Signature of CORI Authorized Employee

*The CHSB Identify Theft Index PIN Number is to be completed by those applicants that have been issued an Identity Theft Index PIN Number by the CHSB. Certified agencies are required to provide all applicants the opportunity to include this information to ensure the accuracy of the CORI request process.

All CORI request forms that include this field are required to be submitted to the CHSB via mail or by fax to 617-660-4614.

_____ _____
Program Manager's Signature Program Manager's Phone