S.H.I.P. 2016
STUDENT HEALTHCARE INTERNSHIP PROGRAM

APPLICATION

DEADLINE FOR SUBMISSION IS FRIDAY, MAY 6TH

Please acknowledge that you will be able to participate in the designated time frame. (June 17th – July 1st)

Name: _____Printed

Name: _____Signed

CONTACT INFORMATION:

Name: _____

Address: _____

City: _____State: _____

Zip Code: _____

Birthdate: _____

Telephone: (Home)_____(Cell)_____

Telephone: (Work)_____(Other)_____

Emergency Contact:

Name: _____Relationship: _____

Telephone:

(Work)_____(Cell)_____

EDUCATION/ACADEMIC INFORMATION:

Name of High School: _____

Overall GPA: _____

Grade in Fall 2016: 9th 10th 11th 12th

Favorite subject: _____

Have you ever participated in the S.H.I.P. Program in the past?

Yes No If so, what year(s)? _____

Healthcare Career Courses completed: _____

_____

Are you a member of HOSA (Health Occupations Student Association)?

Yes No

EMPLOYMENT/VOLUNTEER HISTORY (If Applicable):

Employer: _____ Position: _____

Employer's Telephone: _____

Contact Name: _____

Dates of Employment: _____ to _____

Reason for leaving: _____

Volunteer Work: _____

From _____ to _____Contact Name: _____

APPLICATION DEADLINE, MAY 6TH, 2016

ESSAY:

In your own handwriting, tell us why you want to be in the S.H.I.P. Program by finishing the following phrase in the space provided below (150 words):

"I feel that I would benefit from participating in the SHIP Program because..."

RECOMMENDATIONS:

Two letters of recommendation are required. **Please attach them to this application** and complete the following information about the person who recommended you. *Letters may not be from relatives.*

1. Name: _____ Title: _____

2. Name: _____ Title: _____

COMMUNITY INVOLVEMENT:

Please list any organizations in which you have participated, and your role in each.

_____

_____

_____

_____

What are your plans after high school?

_____

_____

_____

_____

Each Student will rotate through the following departments. Please mark the one that interests you the best. We will try to get you more time in that particular department.

_____Nursing

_____Laboratory

_____Medical Imaging (X-ray, MRI, CT, Ultrasound)

_____Respiratory Therapy

_____Emergency Department

_____Physical Therapy

_____Pharmacy

_____Women's Services (Nursery)

_____Patient Financial Services (Billing)/Quality

_____Materials Management

S.H.I.P. PARENTAL CONSENT FORM:

As the legal parent or guardian of the minor child named below, I hereby provide my consent for him/her to participate in all activities and duties of the NorthCrest Medical Center Student Healthcare Internship Program. I understand that this program provides the opportunity to job shadow and gain useful knowledge about healthcare careers as well as practical work experience. I understand that although this is a five-week program, may child may be withdrawn from this program at any time and for any reason at my or NorthCrest Medical Center's discretion. I also understand that my child must NOT perform any tasks except with the direct supervision/ instruction of qualified hospital personnel. I authorize my child to have a Substance Abuse Screening performed by qualified personnel if there is any reason to suspect this unsuitable behavior. I hereby authorize NorthCrest Medical Center and its representatives to administer any necessary immediate care to my child should he/she be injured while in the course of the S.H.I.P. program.

Child's Name: _____ Date: _____

Parent Name: _____ Date: _____

(Please Print)

Parent Signature: _____ Date: _____

Telephone: _____

This year T-shirts will be required to wear with the NorthCrest/S.H.I.P. logo.

The cost will be $10.00. We will collect the fee if you are selected as a participant.

Please select size: S M L XL 2X 3X