S.H.I.P. 2017
STUDENT HEALTHCARE INTERNSHIP PROGRAM

APPLICATION

DEADLINE FOR SUBMISSION IS FRIDAY, MAY 5TH

Please acknowledge that you will be able to participate in the designated time frame. (June 12 – June 23rd)

Name: ____________________________Printed

Name: ____________________________Signed

CONTACT INFORMATION:

Name: ____
Address: ____
City: ________________________________State: __________
Zip Code: ____
Birthdate: ____
Telephone: (Home)____________________(Cell)_________________
Telephone: (Work)____________________(Other)________________
Emergency Contact:
Name: ________________________Relationship: ___________
T e l e p h o n e :
(Work)____________________(Cell)___________________________

EDUCATION/ACADEMIC INFORMATION:

Name of High School: ______________________________________
Overall GPA: ______________________________________
Grade in Fall 2017: 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)? ____________________________
Are you interested in clinical or non-clinical careers _____________
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 5TH, 2017

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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…"

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

1. Name: ______________________ Title: __________________________
2. Name: ______________________ Title: __________________________

<u>COMMUNITY INVOLVEMENT:</u>
Please list any organizations in which you have participated, and your role in each.
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What are your plans after high school?
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Each Student on the clinical pathway 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.

______Critical Care Unit
______Laboratory
______Medical Imaging (X-ray, MRI, CT, Ultrasound)
______Respiratory Therapy
______Emergency Department
______Physical Therapy

_____Pharmacy
_____Women's Services (Nursery)
_____Medical Surgical Nursing
_____Operating Room/Same Day Surgery
_____Wound Care

Each Student on the non-clinical pathway will rotate through the following departments. Please mark the two that interests you the best. We will try to get you more time in that particular department.

_____Human Resources
_____Information and Technology (IT)
_____Patient Registration
_____Medical Coding
_____Security
_____Plant Operations
_____Materials Management
_____Quality Control
_____Administration

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