**Master’s Level Clinical Internship Application**We are glad you are interested in being a part of our organization! Please read carefully and answer all questions.

|  |
| --- |
|  |
| Name |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Address |  |  | City |  | State |  | Zip code |
|  |  |  |  |  |
| Phone number |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Email address |

**Education**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Name | City and state | Degree/certification obtained and date |
| Technical School, College or University |  |  |  |
| Graduate School or Professional Studies |  |  |  |
| Other Training/Education |  |  |  |

**Professional Experience**Please attach a resume – include current and previous employers, and education history.

**About You**

1. How did you hear about Canvas Health?
2. Current major/area of study?
3. Are you seeking a second/final year clinical internship? [ ]  Yes [ ]  No
4. Have you received services from Canvas Health within the past year? [ ]  Yes [ ]  No
5. List special skills, interests and/or hobbies:

**Previous Volunteer or Intern experience**:

Please list the organizations where you have been a volunteer/intern and describe the type of work performed.

|  |  |  |
| --- | --- | --- |
| Organization | Position | Description of work |
|  |  |  |
|  |  |  |
|  |  |  |

**Internship Program(s) interested in:**

Outpatient Clinic [ ]  School-Based [ ]  Functional Family Therapy [ ]  Crisis Programs [ ]  Family Treatment Program [ ]  Child Day Treatment [ ]

**General Availability *(Canvas accepts September-May & September -August placements)***

|  |  |
| --- | --- |
| Internship start date | Internship end date |
|  |  |

Please rank your preference 1-3.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| Morning |  |  |  |  |  |  |  |
| Afternoon |  |  |  |  |  |  |  |
| Evening |  |  |  |  |  |  |  |
| Overnight |  |  |  |  |  |  |  |
| PreferenceRank |  |  |  |  |  |  |  |

**References**

Please list three non-familial references.

*Information is kept confidential.*

Please inform your references that Canvas Health will be contacting them within the next two weeks. Sign below to authorize Canvas Health to contact your references and verify that all information provided is accurate and complete.

|  |
| --- |
| Reference #1 |
| Name: |  | Relationship: |  |
| Relationship: |  |  |  |
| Years known: |  |  |  |  |  |
| Email address: |  |  |

|  |
| --- |
| Reference #2 |
| Name: |  | Relationship: |  |
| Relationship: |  |  |  |
| Years known: |  |  |  |  |  |
| Email address: |  |  |

|  |
| --- |
| Reference #2 |
| Name: |  | Relationship: |  |
| Relationship: |  |  |  |
| Years known: |  |  |  |  |  |
| Email address: |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Applicant signature |  | Date |

(Typed in name and date accepted)