Bridgeway Center
HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

CLINICAL INTERNSHIP PROGRAM APPLICATION

_____ _____ _____ _____ _____
Last Name First Middle Social Security Number Date

_____ (_____)_____-_____
Present Street Address City/State Zip Code Telephone Number

_____
E-mail Address

Applying as: ☐ Clinical Intern (Under Graduate/Graduate student) ☐ Licensure Intern Type of License: _____

Degree Seeking: ☐ Bachelors ☐ Masters ☐ ARNP ☐ PhD

Clinical Area of Interest: _____

Current School/College/University: _____

Course of Study: _____

Hours Required by Program: (BCI Minimum 400 hours) Practicum: _____ Internship: _____

Academic / Faculty Internship Supervisor: _____
Phone #: _____

Internship Time Period: Start Date: _____ End Date: _____

Days / Hours Available: ☐ Monday: _____ ☐ Tuesday: _____

☐ Wednesday: _____ ☐ Thursday: _____ ☐ Friday:_____

COMMENTS: _____
_____**POST**

HIGH SCHOOL EDUCATION

College / University: _____ Degree: _____Major: _____ Date Degree Awarded: _____

College / University: _____ Degree: _____Major: _____ Date Degree Awarded: _____

College / University: _____ Degree: _____Major: _____ Date Degree Awarded: _____

Are you 18 years of age or older? ☐ Yes ☐ No
Have you ever been convicted of a felony? ☐ Yes ☐ No if yes, give dates and explain: _____

I certify that the answers given herein are true and complete to the best of my knowledge. I authorize the investigation of all matters contained in this application and hereby give Bridgeway Center, Inc. permissions to contact schools, previous/present employers, references and others, and hereby release Bridgeway Center, Inc. from any liability as a result of such contact. I understand that misrepresentations, omissions of facts or incomplete information requested in the application may remove me from further consideration as a Clinical Intern.

I understand that completion of this application in no way constitutes an offer of employment or employment contract.

Clinical Intern Signature: Date:

****** Applicant must attach a current resume******

Do not write below this line. (Internal Use Only)

Aggregate Interview Score: _____ Applicant Ranked _____ out of _____

This applicant has been interviewed and IS / IS NOT recommended for acceptance into the BCI Clinical Internship Program.

Please explain:

_____

_____

_____

_____

RECOMMENDATION REVIEWED AND APPROVED:

Clinical Officer: _____ Date: _____/_____/_____

Human Resources Representative: _____ Date: _____/_____/_____

Chief Executive Officer: _____ Date: _____/_____/_____

Applicant Informed of Decision:

Name: _____ Date: _____/_____/_____ Time: _____ a.m. / p.m.

Clinical Intern Assigned as follows:

Program: _____ Site Supervisor: _____

Clinical Mentor: _____Contact #: _____

Starting Date: _____/_____/____ Ending Date: ____/____/_____

Days / Hours: _____

_____

_____

_____

Duties: _____

_____

_____

_____