Phone: 417-347-5830



Education Department

Clinical Internship Application					
Personal Information: Print or Type					
SSN (Full):		Date of b			
, ,					
Name:					
Last	Fir	rst	Middle		
Current Address:					
Street	Cit	ty	State	Zip	
Phone #:	Ok to text: Ye		es No		
	_				
Email:				_	
School/Program Name/Grad Date:					
School/110gram Name/Grau Date.	School/Pr	rogram Name	Gra	aduation Date	
School Coordinator's Name & Contact Info	:				
Current Freeman Employee: Yes No	For	rmer Freemai	n Employee: Yes	No	
All internships are unpaid. Internships may no	t be compl	eted on the clo	ock or in vour currer	nt department/s.	
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D	. 1	1 . 1	. 1.		
Rotations Requested: We will do our best to m Requested Specialty & Preceptor Name (if kr		Start Date	End Date	Reg. # of Hours	
	iowii)	Start Date	Liid Date	Req. # Of Flours	
1.					
2.					
3.					
4.					
5.					
Freeman Health System requires the following	informati	on along with	vour application at	least 45 days prior to the	
scheduling of your rotation. We reserve the rig					
timely.					
All applicants must provide the following:	the following: Additional documents for non -Freeman employees: Attestation from school that includes that student has met				
□ Internship application					
□ Letter of good standing from school		-	listed in the affiliati	=	
□ Proof of liability insurance □ Photo ID in JPEG format		-Vaccination/declination for MMR, TB, Hep B, COVID, and Flu -Comprehensive Criminal Background Check			
	-Comprenensive Criminal Backgro -Drug Screen		Cililliai Backgroui	iu Check	
☐ Copy of evaluation needed for school☐ Copy of BLS certification	-D:	rug Screen			
= copy or big certification					
Student Signature				Date	