



Please complete each of the items and return to StudentInternship@gulfside.org along with your most current resume. We appreciate your interest in interning with the team of experts at Gulfside Healthcare Services.

Personal Information:

Date:

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____

Preferred Method of Communication: Email Mail Phone

Emergency Contact Information:

Name: _____

Phone: _____ Relationship: _____

College/University Information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Current Degree Seeking: _____ Current GPA: _____

Desired Start Date: _____ Desired Internship End Date: _____

Internship Area of Interest: _____

Program Supervisor: _____ Supervisor Number: _____

Hours Required Weekly: _____ Total Hours Required: _____

Educational Institution History:

High School: _____ Degree: _____ Year: _____

Associates: _____ Degree: _____ Year: _____

Bachelor's: _____ Degree: _____ Year: _____

Graduate: _____ Degree: _____ Year: _____

Skills:

Do you know a foreign language? Yes No

If yes, please specify language(s): _____

Please list special skills and/or hobbies you have:

What organizations do you belong to (if applicable)? _____

Armed Forces or Veterans Status:

Have you ever served in the Armed Forces: Yes No

Are you currently in the Armed Forces? Yes/Full Time Yes/Reserves No

If yes, which branch? _____

Physical Health:

All interns working in a patient care related area must provide proof of annual TB Test and annual Flu Vaccine. If annual Flu Vaccine is declined, intern must wear mask when working in patient related areas.

Date of your last TB test: _____ Date of your last flu vaccine: _____

Do you have any physical restrictions that might limit your intern placement in specific areas with Gulfside?

Yes No

If yes, please specify:

AGREEMENT:

I certify that answers given herein are true and complete to the best of my knowledge. I authorize investigation of all statements contained in this Student Internship application as deemed necessary for internship participation. I understand that this application is not intended to be an offer of employment. In consideration of being a Gulfside Healthcare Services intern, I do hereby assume the risk of injury and all medical expenses incurred from any injury resulting from my internship participation. I understand, acknowledge and agree I am not covered by Workers' Compensation Insurance or benefits provided there under and I do hereby release, discharge and hold harmless Gulfside Healthcare Services, its agents, representatives and employees from any and all claims whatsoever, known or unknown, for damages or injuries to myself.

Print Name: _____

Signature: _____

Date: _____

Return Application electronically or via mail to:

StudentInternship@gulfside.org

Gulfside Healthcare Services

Attn: Student Internship Program

2061 Collier Parkway

Land O Lakes, FL 34639