

ALLIED HEALTH INTERNSHIP PLAN FORM

NAME _____ Phone _____

ADDRESS _____ email _____

City _____ State _____ Zip _____

Type of visit requested: (Check the type of internship requested)

- 2 week internship for the allied health minor
- 2 week internship for the B.S. in health sciences
- _____ weeks (indicate # of weeks) for major in Health Care Administration

_____ Proposed Dates _____

Name of Facility _____

Address _____

City, State, Zip _____

Contact Person/Title _____

Telephone # _____ Fax _____

(If you are breaking your internship into different sites and times indicate your preference for remaining dates and sites below. Use a 2nd form if more space is needed.)

_____ Proposed Dates _____

Name of Facility _____

Address _____

City, State, Zip _____

Contact Person/Title _____

Telephone # _____ Fax _____

_____ Proposed Dates _____

Name of Facility _____

Address _____

City, State, Zip _____

Contact Person/Title _____

Telephone # _____ Fax _____

STATEMENT OF UNDERSTANDING: I have reviewed the objectives, grade scale, and report requirements for the allied health internship.

The grade that I have selected to work towards is a(n) _____.

_____ Date _____ Student Signature _____

SUBMISSION DEADLINE	Return Completed Applications To
8 weeks prior to desired internship date.	Teri Stubbs, RHIA Director, HCA Program, SW0SU 100 Campus Drive Weatherford, OK 73096 Science 202c Phone: 580-774-3067 Fax: 580-774-3795

