

**HEALTH SCIENCE INTERNSHIP PROGRAM DATA**

Name: \_\_\_\_\_

Home School: \_\_\_\_\_

Are you employed? \_\_\_\_\_ If so, where? \_\_\_\_\_

GPA \_\_\_\_\_ ACT \_\_\_\_\_

How many days were you absent this school year? Circle One:

0 – 5 days

6-10 days

>10 days

How many were excused? \_\_\_\_\_ How many tardies this school year? \_\_\_\_\_

Do you have a discipline record (Grades 9 – 11)? Yes No

Have you paid your fees for Health Science this year? Yes No

**Cost of Health Science Internship is \$80.00.**

Do you have your own transportation to get to clinicals? Yes No

Do you have a driver's license? Yes No

Do you have car insurance? Yes No

Do you have health insurance? Yes No

- On the back of this form, please describe what you hope to gain from the Health Science Internship class and what you can contribute to this class.
- List 2 alternative elective classes to be removed if chosen for Internship:

○ \_\_\_\_\_

○ \_\_\_\_\_