

**Children's Memorial Hospital
Chicago, Illinois**

Child Life and Art Therapy Internship Application

Date _____
Applying for: Fall ____ Winter/Spring ____ Summer ____ Focus: Child Life ____ Art Therapy ____
Name _____ Phone (Day) _____ (Evening) _____
Address _____ City _____ State ____ Zip _____
E-mail address _____

Academic Background

University/College _____ Dates Attended (Month/Year) From _____ To _____
Major _____ Minor/Areas of Emphasis _____
Graduation Date _____ Degree Earned _____ GPA _____

University/College _____ Dates Attended (Month/Year) From _____ To _____
Major _____ Minor/Areas of Emphasis _____
Graduation Date _____ Degree Earned _____ GPA _____

College Courses in Child Development, Child Life, Expressive Therapies or Related Medical Courses*
(Completed or in process of completion)

Course Title	Grade Earned
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

*Please include an official copy of your college transcripts

Experience with Hospitalized Children

Child Life or Art Therapy Practicum* Yes No (If no, please continue to next section)

Name of Institution _____ Department _____

Address _____

Dates (Month/Year) From _____ To _____ Hours per week _____ Total Hours _____

Briefly describe population and responsibilities _____

Practicum Supervisor _____ Telephone Number _____

*Please attach a copy of your certificate of completion or a letter from your supervisor

Hospital or Health Care Volunteer Experience* Yes No (If no, please continue to next section)

Did you work with a pediatric population? Yes No

Were you supervised by a Child Life Specialist? Yes No or Art Therapist? Yes No

Name of institution _____ Department _____

Address _____

Dates (Month/Year) From _____ To _____ Hours per week _____ Total hours _____

Briefly describe population and responsibilities _____

Volunteer Supervisor _____ Telephone number _____

* Please attach a letter from your supervisor that includes a brief description of your experiences and hours completed.

Art Therapy/Child Life Work Experience Yes No (If no, please continue to next section)

Name of institution _____ Department _____

Address _____

Dates (Month/Year) From _____ To _____ Hours per week _____ Total hours _____

Briefly describe population and responsibilities _____

Supervisor _____ Telephone number _____

Other Experience with Children, Adolescents and Families

(do not repeat experiences listed previously on this application)

Name of Agency _____ Experience related to ___ work ___ school ___ volunteering

Address _____ Position/Title _____

Dates (month/year) From _____ To _____ Hours per week _____ Total hours _____

Briefly describe population and responsibilities _____

Supervisor _____ Phone Number _____

Name of Agency _____ Experience related to ___ work ___ school ___ volunteering

Address _____ Position/Title _____

Dates (month/year) From _____ To _____ Hours per week _____ Total hours _____

Briefly describe population and responsibilities _____

Supervisor _____ Phone Number _____

Name of Agency _____ Experience related to ___ work ___ school ___ volunteering

Address _____ Position/Title _____

Dates (month/year) From _____ To _____ Hours per week _____ Total hours _____

Briefly describe population and responsibilities _____

Supervisor _____ Phone Number _____

Professional, School and Community Involvement

List organizations you are currently or recently involved in _____

References

Please provide three references, including at least one professor and one professional who has seen you interact with children. References can include professionals previously mentioned on this application.

Name _____ Organization/Agency _____

Agency address _____ City _____ State _____ Zip _____

Relationship to you _____ Daytime phone number _____

Name _____ Organization/Agency _____

Agency address _____ City _____ State _____ Zip _____

Relationship to you _____ Daytime phone number _____

Name _____ Organization/Agency _____

Agency address _____ City _____ State _____ Zip _____

Relationship to you _____ Daytime phone number _____

College Enrollment Information

Will you be using the internship to complete college credits? ____ Yes ____ No

If yes, what college? _____

College site supervisor name _____

Address _____ Phone Number _____

Please Enclose

- ____ A copy of your official transcripts
- ____ Practicum certificate OR letter from your practicum supervisor, if applicable
- ____ Letter from your volunteer supervisor, if applicable
- ____ A copy of your current resume
- ____ Non-refundable fee of \$10, made payable to Children's Memorial Hospital. Do not send cash.

I confirm that the information provided in the application is true to the best of my knowledge. I further understand that any false statements on the application shall be sufficient cause for rejection for this internship or immediate discharge when discovered.

I hereby authorize my former supervisors and references to release information regarding my past experiences to assist this committee in determining my suitability for the internship.

Applicant's signature _____ Date _____

Please return completed application and materials to:

Victoria Storm
Manager, Children's Services, Child Life Team
Children's Memorial Hospital
2300 Children's Plaza, Box 31
Chicago, IL 60614

Please direct any question to 773-880-3118.

Children's Memorial Hospital's internship selection committee does not discriminate on the basis of race, creed, ancestry, color, religion, sex, national origin, age, marital status or disability. We reserve the right to not offer the internship every semester.