



Office Use Only:
 Date Received: _____
 Contact Date: _____
 Orientation Date: _____
 Start Date: _____

**ALAMANCE COUNTY HEALTH DEPARTMENT
 STUDENT/VOLUNTEER/INTERN APPLICATION**

Full Name: _____
Last
First
Middle

Address: _____

City
State
Zip

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Date of Birth: _____ Gender: _____
 (Month /Day/Year) (Male/Female)

Person to be notified in case of an Emergency:

Full Name: _____
Last
First
Middle

Relationship: _____

Address: _____

City
State
Zip

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Age: Under 18 Over 18

Please check the category that applies to you:

- Student:** Someone who is required to perform a given number of service hours in order to meet a school requirement.
- Intern:** Someone who earns course credit for on-site work experience with the Health Department while attending a school of higher education.
- Volunteer:** Someone who performs hours of service for the Health Department without promise, expectation or receipt of compensation for services rendered.

In which Health Department Program/Area would you prefer to work? *

- Clinical Services Health Education and Promotion / Public Information
- Environmental Health Dental Administration
- WIC/Nutrition Services Clerical/Finance Not sure/No preference / Other _____

**Please note all requests for placement as a student, volunteer, or intern are based upon the needs of the agency and are not guaranteed.*

Time Commitment and Availability:

Availability (Please check the days and times you are available)						
Sunday*	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday*
<input type="checkbox"/> Morning	<input type="checkbox"/> Morning	<input type="checkbox"/> Morning	<input type="checkbox"/> Morning	<input type="checkbox"/> Morning	<input type="checkbox"/> Morning	<input type="checkbox"/> Morning
<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon	<input type="checkbox"/> Afternoon
<input type="checkbox"/> Evening	<input type="checkbox"/> Evening	<input type="checkbox"/> Evening	<input type="checkbox"/> Evening	<input type="checkbox"/> Evening	<input type="checkbox"/> Evening	<input type="checkbox"/> Evening

**Please note that Saturday and Sunday opportunities are very infrequent. The Health Department's normal hours of operation are Monday through Friday, from 8:00 A.M. until 5:00 P.M.*

What hours are you available? (Be specific) _____

Total Hours needed (if you have a requirement). _____ Beginning date _____ to _____

If you require special accommodations per the Americans with Disabilities Act, please indicate here.

Yes No

If yes, what accommodations will you need? _____

How did you hear about our organization? _____

Have you ever been convicted of a criminal offense other than a minor traffic offense? Yes No

If yes, please explain:

References: (Non-relative; known for at least one year)

Full Name: _____
Last First Middle

Address: _____

City State Zip

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Full Name: _____
Last First Middle

Address: _____

City State Zip

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Do you have a valid Driver's License? Yes No

If so, list Number _____ State of Issuance: _____

PLEASE NOTE: You may attach a résumé and/or additional pages if you feel space is limited.

	Name and Location	Major	Degree Obtained
High School		High School Diploma Received? <input type="checkbox"/> Yes <input type="checkbox"/> No GED Received? <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No	
College			
Graduate School			
Other			

Volunteer and Paid Experience				
Employer	Position	Duties	Dates	Reason for Leaving

Applicable Licenses or Certificates			
Type	Number	Date Issued	Expiration Date

LANGUAGES: Indicate language other than English and check the skill that applies to you.			
Language	Speaking Ability	Reading Ability	Writing Ability
	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High

ADDITIONAL INFORMATION: Please attach additional pages if necessary.

Please describe your experience, work or otherwise, which you feel may be helpful in the type of position in which you are interested.

What skills do you hope to gain or improve on during your experience?

How do you think that the Alamance County Health Department would contribute to your understanding of Public Health?

Explain any special skills or interests that you have that could contribute to your experience.

Why do you want to volunteer at this type of organization?

What are your goals or objectives in terms of professional or personal development and what role does the Alamance County Health Department play?

Certification

I certify the information given in this application is complete and correct. I further understand that discovering information to the contrary may be cause for re-determination of my volunteer, student, or internship assignments with the agency.

I certify that I am covered by an independent insurance carrier and that Alamance County will not be held responsible for any injuries that I may incur as a result of my volunteer, student, or internship services for the County.

Signature: _____ Date: _____

If Volunteer is under 18 years of age:

I give permission for my child/ward to be a volunteer at this agency. I certify that my child/ward is covered by an independent insurance carrier and that Alamance County will not be held liable for any injuries that my child/ward may incur as a result of these volunteer, student, or internship services for the County.

Signature: _____ Date: _____

STUDENT/INTERN CONSENT FORM

Print Name

Department/Program Assignment

HOLD HARMLESS/RELEASE AGREEMENT

I understand and acknowledge that there may be a risk inherent in work associated with Alamance County Government, by agreeing to serve, the intern, in conjunction with the Educational Institution, hereby assumes all risks which may arise from providing these services. Interns, by agreeing to serve as such and in return for the provision of said opportunity, will indemnify and hold harmless the County of Alamance from any and all claims for liability, loss, injury, damages, costs or attorney's fees brought against Alamance County or any of its agents, employees, or commissioners arising out of any personal injury, wrongful death, or other damage sustained by a client or agent of the County due to services provided by the Intern. Any professional liability insurance under which said intern would be covered should be carried by the intern or in conjunction with the educational institution as required by their intern's placement with Alamance County.

Agreed between the parties on this the _____ day of _____, _____.

Student Intern Signature

CONSENT TO SEEK EMERGENCY MEDICAL CARE

This is to authorize the department to seek emergency medical care if, in the judgment of the staff it is needed, for a medical emergency. It is understood and agreed that the said staff, the department/program, and Alamance County will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported.

Date _____ Student/Intern _____

Date _____ Witness _____

Name of local physician _____ Phone _____

Emergency contact person (local) _____ Phone _____

CONSENT TO BE TRANSPORTED

It is understood and agreed that the said staff, the department/program and Alamance County will be held harmless in case of accident or injury to the student or intern while participating in program activities and while being transported to and from activities

Date _____ Student/Intern _____

Date _____ Witness _____

If you are volunteering/interning as a part of a class or other requirement, please provide a brief description of the requirements.

**Return to: Angela Harris
Human Resources Specialist
Alamance County Health Department
319 N. Graham-Hopedale Rd. STE B
Burlington, NC 27217
(336) 513-5512
angela.harris@alamance-nc.com**

For ACHD Use Only

Student/Intern/Volunteer Placed: Yes No

Division Assigned/Placed: _____

Beginning Date: _____ To: _____

Location: _____

To Be Supervised By: _____

Tentative Hours: _____

Supervisor's Phone: _____