Riverside University HEALTH SYSTEM Public Health

STUDENT INTERN APPLICATION

COMMUNITY OUTREACH

Full Name: _____ Date: ___ /___ /___

Address: _____APT.#_____ Home Phone: (___) _____

City: _____ State: _____ Zip: _____ Cell Phone: (___) _____

Date of Birth: _____ Email: _____

Driver's License No: _____ Expiration Date: _____

Do you have auto insurance? Yes___ No___

Do you have a physical or medical problem, which may limit your ability to perform as an intern?
Yes____ No____ If yes, briefly explain:_____

ALL INTERNS WILL BE SUBJECT TO A CRIMINAL BACKGROUND CHECK

Are you currently on any form of Probation or Parole? Yes_____ No _____ Date of offence: _____

Have you ever been convicted of a felony or misdemeanor? Yes ___ No ___.
If "Yes": Date: ____/____/____ Charge/Sentence: _____City: _____
(A conviction record <u>will not</u> automatically disqualify you from an internship)

EMPLOYER INFORMATION

List current or most recent employer first

Company Name: _____ Phone: _____
Address: _____ From: _____ To _____
City: _____ State: _____ Zip: _____
Job Title/Duties: _____

Company Name: _____ Phone: _____
Address: _____ From: _____ To _____
City: _____ State: _____ Zip: _____
Job Title/Duties: _____

EDUCATION

Circle the highest grade of school you have completed:
High School: 1 2 3 4 College: 1 2 3 4 5 6 Graduate: 1 2 Other: _____

What degrees or certificates do you have? _____
Are you currently a student? _____ If yes, complete below:

_____	_____	_____	_____
SCHOOL ATTENDING	CITY	STATE	FIELD OF STUDY/MAJOR

ADDITIONAL INFORMATION ON BACK

INTERESTS:

Have you interned with the County of Riverside in the past? Yes ___ No ___

If Yes, Date: ___/___/___ Department? _____

What foreign languages do you speak? _____

List computer programs you work with? _____

Please list all certificates, documents, licenses and professional designations: _____

_____

How did you learn about the Department of Public Health's Student Intern Program? _____School _____Internet _____Friend _____Employee Other: _____

How many hours are required for your internship? _____ Months? _____to _____

EMERGENCY CONTACT INFORMATION:

In Case of an emergency contact the following individual

Name: _____ Relationship: _____

Address: _____ Telephone: (____)_____

City: _____ State ____ Zip _____

Please check the area(s) in which you would be interested in completing your internship:

___Children Medical Services	___Epidemiology	___ Disease Control
___Public Health Nursing	___Injury Prevention	___ Family Planning
___Immunization Program	___Nutrition Services	___HIV/AIDS
___Public Health Laboratory	___Oral Health Program	___Tobacco

___Other: _____

Please submit completed application in person or mail to: DOPH- Community Outreach
4065 County Circle Dr. Suite 205, Riverside, CA. 92503
(951) 358-5031 ~ WWW.RIVCOOUTREACH.ORG

I, _____ HAVE RECEIVED AND READ THE VOLUNTEER/INTERN SERVICES HANDBOOK.
Print Full Name

BY MY SIGNATURE BELOW, I DECLARE THAT ALL INFORMATION PROVIDED ON THIS DOCUMENT SUBMITTED TO THE COUNTY OF RIVERSIDE IS TRUE AND COMPLETE. I UNDERSTAND THAT FALSIFICATION OF INFORMATION IS GROUNDS FOR DISQUALIFICATION. I AUTHORIZE THE COUNTY AND ANY OF ITS AGENTS TO VERIFY ANY INFORMATION ON THIS APPLICATION AND I AUTHORIZE RELEASE OF ANY SUCH INFORMATION. I RELEASE THE COUNTY OF ANY LIABLILITY FOR SEEKING SUCH INFORMATION. I ALSO FULLY UNDERSTAND AND AGREE TO UPHOLD ALL POLICIES AND PROCEDURES OF THE COUNTY OF RIVERSIDE ,DEPARTMENT OF PUBLIC HEALTH AS STATED IN THE VOLUNTEER/INTERN SERVICES HANDBOOK. BY COMPLETING THIS APPLICATION, I UNDERSTAND THAT I AM COMMITTING MYSELF TO THE COUNTY OF RIVERSIDE, DEPARTMENT OF PUBLIC HEALTH, COMMUNITY OUTREACH DEPARTMENT, VOLUNTEER SERVICES PROGRAM FOR THE PERIOD AGREED UPON. I AGREE TO ABIDE BY THE COUNTY OF RIVERSIDE CODE OF ETHICS AND WILL HOLD IN STRICT CONFIDENCE ALL INFORMATION THAT IS ACQUIRED THROUGH SERVICE THAT IS DEFINED BY THE FEDERAL PRIVACY ACT (HIPAA) AND THE STATE OF CALIFORNIA AS CONFIDENTIAL. I WILL ASSUME ALL RISKS OF INJURY OCCURING TO ME WHILE RENDERING MY SERVICES AND HEREBY HOLD HARMLESS AND RELEASE THE COUNTY OF RIVERSIDE DEPARTMENT OF PUBLIC HEALTH FROM ANY AND ALL CLAIMS. I DO NOT HAVE PROPERTY INTEREST IN THE POSITION AND MY VOLUNTEER SERVICE IS AT WILL. I RECOGNIZE THAT I CAN BE REMOVED FROM THE POSITION AT ANY TIME, WITHOUT CAUSE AND WITHOUT THE RIGHT TO AN ADMINISTRATIVE REVIEW OF MY REMOVAL.

Signature _____ Date: ___/___/___

Revised 6/19