Request for Practical Experience in Public Health [Internship]

Student Information:

Student Name:	Phone Number:
Mailing Address:	Email:

Shool or Institution Information:

School or Institution:	College or Program:
Contact Name and Title:	Phone:
	Email:
Major or Degree and Concentration:	Expected Graduation Date:
Is this Experience required for graduation? [ ] Yes [ ] No	Does this experience require an evaluation or grade from the preceptor? [ ] Yes [ ] No
Expected start date for experience?	Expected end date for experience?
Brief description of goals and objectives of this experience. Please include the potential benefits of this experience for the student and for East Liverpool City Health District. Use an additional page if necessary.	
Signature of Student:	Date:

Return this request to: Carol Cowan, Health@eastliverpool.com

05/2020