

APPLICATION FORM

Application Form for Interns

Office of the Health Strategy

SECTION 1 – Applicant Instructions

Please print or type all answers to all questions.

A complete application includes a cover letter, resume or CV, and the form below.

Mail completed application to: Jeannina Thompson

Office of Health Strategy

Mailing Address: 450 Capitol Avenue, MS #51OHS, P.O. Box 340308, Hartford, CT 06134-0308

If you have questions, please contact Jeannina Thompson at 860-418-7079 or jeannina.thompson@ct.gov

SECTION 2 – Applicant Information

Applicants must be at least 18 years old.

INTERN OTHER

Applicant's full name:

Applicant's home address:

City/Town:

State:

Zip Code:

Home telephone:

Work Telephone:

Date of birth:

Driver's license: Yes No

State:

Operator's license number:

Primary vehicle registration tag:

Make/Model/Year of vehicle:

SECTION 3 – Education

Education (check)

Graduated High School GED Associates Bachelors Masters Post Graduate

SECTION 4 – References

Name:

Name:

Address:

Address:

Telephone number:

Telephone number:

Relationship:

Relationship:

SECTION 5 – Employment Information

Are you an employee or have you ever been employed by OHS? No Yes

Instructions: Beginning with your PRESENT or MOST RECENT employment please clearly describe the work (duties/responsibilities) you personally performed.

Job Title:

Company name:

Type of business:

Department where assigned:

Supervisor's name:

Telephone number:

Employed from (date):

Total time (years/months):

Hours per week:

FT

PT

SECTION 6 – Previous/Present Intern Experience

Instructions: Beginning with your PRESENT or MOST RECENT intern experience please clearly describe the work (duties/responsibilities) you personally performed.

Previous/Present intern service (title):

Name of organization:

Contact person:

Telephone number:

Duties/responsibilities:

SECTION 7 – Medical/Emergency Contact Information

Medical Information:

Emergency Notification:

Physician:

Name:

Telephone number:

Telephone number:

Insurance company:

Relationship:

SECTION 8 – Certification

I certify that the statements made by me on this application are true and complete to the best of my knowledge, and are made in good faith. I understand that any misstatement of fact may result in termination. All statements made on this application, including employment information are subject to verification as a condition for OHS service. By affixing my signature below, I give OHS authorization to contact personal references and employers as a condition of approval for service.

Applicant signature:

Date:

End Box Office Use

Accepted _____ Rejected _____

Hours ____/wk.

Start Time ____ End Time ____