



Intern/Clinical Supervision Application

Contact Information

Name (Full Legal Name)	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	
Social Security #	
Date of Birth	

Purpose of Internship/Clinical Supervision

University/College Attending _____

Degree Working Toward _____

Number of Total Hours Required For Internship _____

Do you require a Licensed Clinical Supervisor? ☐ Yes ☐ No If yes, what credential? _____

Do you have a supervisor/unit in mind? _____

What kinds of activities/work do you need to fulfill the course requirements for this internship?

Availability

During which hours are you available for intern assignments?

- | | |
|---|---|
| <input type="checkbox"/> Weekday mornings | <input type="checkbox"/> Weekend mornings |
| <input type="checkbox"/> Weekday afternoons | <input type="checkbox"/> Weekend afternoons |
| <input type="checkbox"/> Weekday evenings | <input type="checkbox"/> Weekend evenings |

What date are you available to start? _____

When must you be finished with your hours? _____

Interests

Tell us in which areas you are interested in interning

Administration

Children's Mental Health

Adult Mental Health

Children with Intellectual Developmental Disabilities

Adults with Intellectual Developmental Disabilities

Early Childhood Intervention

Other – Please specify

Special Skills or Qualifications

Summarize special skills and qualifications you have acquired from employment, previous volunteer work, or through other activities, including hobbies or sports.

Previous Volunteer Experience

Summarize your previous volunteer experience.

Person to Notify in Case of Emergency

Name	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Professor/Teacher Providing Course Oversight

Name	
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Title	
Street Address	
City ST ZIP Code	
Home Phone	
Work Phone	
E-Mail Address	

Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

Name (printed)	
Signature	
Date	

Our Policy

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

I understand that the internship with Betty Hardwick Center will be contingent upon acceptable driving record, background check, and drug screen. If any of these are considered to be unacceptable – or if any misstatements are found in my application – I understand that an internship may be withdrawn or terminated.

Thank you for completing this application form and for your interest in interning with us.

Approval and Assignment

This application ____ is ____ is not approved for dates requested. JOB DESCRIPTION MUST BE ON FILE IN HR PRIOR TO START DATE ALONG WITH TRAINING RECORD INDICATING REQUIRED COURSES.

Clinical/Administrative Supervisor

Date

Division Chief

Date

Human Resources

Date

Chief Executive Officer

Date

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____ have been notified that a computerized criminal
APPLICANT or EMPLOYEE NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure
Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent
true identification to criminal history, the organization (as listed below) conducting the criminal history check is
not allowed to discuss any information obtained using this method, therefore the agency may offer the
opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the
search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for
analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have
been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from
this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of
\$24.95 to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my
fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

Signature of Applicant or Employee

Date of Signature

Date of Birth

Agency Name (Please print)

Agency Representative Name (Please print)

Signature of Agency Representative

Date

Check and Initial each Applicable Space

CCH Report Printed:

YES _____ NO _____ initial

Purpose of CCH: _____

Hire _____ Not Hired _____ initial

Date _____ initial

Destroyed _____ initial

Retain in your files FOR HR TO FILL