



**ARMS ACRES
INTERNSHIP APPLICATION**

PLEASE PRINT

Student Name:		
Street Address:		City/State:
Primary Phone:	Secondary Phone:	Email:
Academic Affiliation and Address:		
Degree Program:		
Faculty Advisor Name:		Faculty Advisor Contact Information:
		Address:
		Telephone:
		E-mail:
Internship Start Date:		Internship End Date:
Hours Required Weekly:		Hours Required Per Semester:
Please Provide the Days and Hours/Per Day You are Available:		
Monday:	Tuesday:	
Wednesday:	Thursday:	
Friday:	Saturday:	Sunday:

Following an initial interview prospective interns are asked to contact Human Resources at (845) 225-3400 X6132 to schedule fingerprinting. ***Human Resources will be your contact for all required information, forms and deadlines and any questions you may have pertaining to them. In order to maintain your place on our waitlist, all documentation must be returned with 72 hours of receipt.***

Acceptance into the Arms Acres Intern Program is not determined until all required documentation is returned and reviewed. This includes but is not limited to background checks, fingerprinting, medical clearance and drug testing results. Please note anyone failing to pass a drug test will not be eligible to intern. You will be notified of your acceptance into The Arms Acres Intern Program by The Human Resources Department. The Coordinator of Family Services and Clinical Interns will work with prospective interns to finalize placements that are beneficial to both the student and Arms Acres. ***This process can take up to 3 weeks.***

There is one mandatory meetings for all incoming interns. The first is Arms Acres Employee/Intern Orientation. The Human Resources Department ***will notify you*** of your Orientation Date. ***You will not be able to attend this training or orientation unless all background is cleared and all necessary documentation is submitted.*** Please note that Orientations are held only on Wednesday from 8:00 am – 4:00 pm.

It is understood that performance under this Internship Agreement will occur within the confines of what is allowed under HIPAA and 42CFR Part 2 to facilitate the best possible outcomes for our patients. I understand and agree to abide by the above,

Signed: _____ **Date:** _____