Clinical Intern Application

I. Personal Information

Last Name:	First Name:
Address:	
Social Security Number:	Date of Birth:
Cell Phone:	Home Phone:
Email Address:	Driver's License/State ID State & Number:

II. Educational Background, Goals, & Skills

Please list the name of your graduate school, what program you are in, and what stage of the program you are in:
School Internship Point of Contact (Name, Email Address, Phone Number):

If different from the above contact, please list the name, phone number, and email address of the person at your school to whom you are accountable for clients and who we should contact if there are concerns about your clinical work:
Expected Internship Start Date: ________________________ End Date: ______________________
Please describe the requirements outlined by your school for your internship (number of client hours, supervision arrangements, etc.):
Does your school require formal feedback from your internship supervisor regarding your work with clients? If yes, please describe what is required.

Will you receive any other type of supervision or instruction related to this experience? If yes, please describe:
Have you ever received clinical supervision? If yes, please provide details about what that included and what the experience was like for you and how it could have been improved.
Does your school or employer have its own policy and procedural manual for clinical internships? If so, please attach a copy.
How do you currently (or plan to) evaluate your client work and are you open to additional evaluation strategies?

Undergraduate College/University Attended:	Degree(s):	Year Graduated:
Please describe your professional goals.		
Please describe your experience working with autistic/neurodivergent individuals and families impacted by autism:		
Do you speak other languages? If so please list.		
Do you have special talents or hobbies (e.g. art, sports, cooking etc.)		

III. Certifications (Please indicate the organization(s) through which you are certified, and enclose a copy of your certifications.)

☐ CPR	Expiration:
☐ First Aid	Expiration:
☐ Professional Certifications/Licenses (List):	Expiration(s):

IV. General Employment Experience (begin with most recent)

Employer:	Phone:
Address:	Fax:
Position:	Dates:
Salary:	Supervisor:
Describe responsibilities of position:	
Reason for leaving:	

Employer:	Phone:
Address:	Fax:
Position:	Dates:
Salary:	Supervisor:
Describe responsibilities of position:	
Reason for leaving:	

Employer:	Phone:
Address:	Fax:
Position:	Dates:
Salary:	Supervisor:
Describe responsibilities of position:	
Reason for leaving:	

IV. References

List three people, other than relatives or personal friends, who know you professionally or academically. At least one reference should be someone who has worked with or supervised you, if possible.

Name:	Relationship & Company:
Phone:	Email Address:

Name:	Relationship & Company:
Phone:	Email Address:

Name:	Relationship & Company:
Phone:	Email Address:

V. Questionnaire

Have you ever been charged with or convicted of a felony?

- ☐ Yes
- ☐ No

Have you ever been charged with, or found guilty of committing an act of physical, sexual or any type of child abuse?

- ☐ Yes
- ☐ No

Do you require any special accommodations in order to perform your job responsibilities?

- ☐ Yes
- ☐ No

I authorize Have Dreams to conduct an independent background investigation of me. I further authorize Have Dreams to request/receive any information pertaining to me including criminal, past employment, education and/or references from any persons, schools, or previous employers. I acknowledge that this information may be used by Have Dreams staff throughout my hiring process.

Applicant Signature: ____ Date: __________________