Office Use Only:
Date Received: ___________
Contact Date: ___________
Orientation Date: ___________
Start Date: ___________

ALAMANCE COUNTY HEALTH DEPARTMENT
STUDENT/VOLUNTEER/INTERN APPLICATION

Full Name: ____
Last First Middle

Address: ____

____
City State Zip

Home Phone: _______________ Cell Phone: _______________ Email: _____________

Date of Birth: _______________ Gender: ___________
(Month /Day/Year)

Person to be notified in case of an Emergency:

Full Name: ____
Last First Middle

Relationship: ______________________________

Address: ____

____
City State Zip

Home Phone: _______________ Cell Phone: _______________ Other Phone: _____________

Age: ☐Under 18 ☐ Over 18

Please check the category that applies to you:

☐ **Student**: Someone who is required to perform a given number of service hours in order to meet a school requirement.

☐ **Intern**: Someone who earns course credit for on-site work experience with the Health Department while attending a school of higher education.

☐ **Volunteer**: Someone who performs hours of service for the Health Department without promise, expectation or receipt of compensation for services rendered.

In which Health Department Program/Area would you prefer to work? *
☐ Clinical Services ☐ Health Education and Promotion / Public Information
☐ Environmental Health ☐ Dental ☐ Administration
☐ WIC/Nutrition Services ☐ Clerical/Finance ☐ Not sure/No preference / Other ______________

Please note all requests for placement as a student, volunteer, or intern are based upon the needs of the agency and are not guaranteed.

Time Commitment and Availability:

Availability (Please check the days and times you are available)						
Sunday*	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday*
☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening	☐ Morning ☐ Afternoon ☐ Evening

Please note that Saturday and Sunday opportunities are very infrequent. The Health Department's normal hours of operation are Monday through Friday, from 8:00 A.M. until 5:00 P.M.

What hours are you available? (Be specific) ____

Total Hours needed (if you have a requirement). __________ Beginning date ___________ to ___________

If you require special accommodations per the Americans with Disabilities Act, please indicate here.
☐ Yes ☐ No

If yes, what accommodations will you need? ____

____

How did you hear about our organization? ____

Have you ever been convicted of a criminal offense other than a minor traffic offense? ☐Yes ☐No

If yes, please explain:

____

____

References: (Non-relative; known for at least one year)

Full Name: ____
Last First Middle

Address: ____

____
City State Zip

Home Phone: __________________ Cell Phone: ____________________ Other Phone: ________________

Full Name: ____
Last First Middle

Address: ____

____
City State Zip

Home Phone: __________________ Cell Phone: ____________________ Other Phone: ________________

Do you have a valid Driver's License? ☐Yes ☐No

If so, list Number _______________________ State of Issuance: ____________________________

PLEASE NOTE: You may attach a résumé and/or additional pages if you feel space is limited.

	Name and Location	Major	Degree Obtained
High School		**High School Diploma Received?** ☐ Yes ☐ No **GED Received?** ☐ N/A ☐ Yes ☐ No	
College			
Graduate School			
Other			

Volunteer and Paid Experience				
Employer	Position	Duties	Dates	Reason for Leaving

Applicable Licenses or Certificates			
Type	Number	Date Issued	Expiration Date

LANGUAGES: Indicate language other than English and check the skill that applies to you.			
Language	Speaking Ability	Reading Ability	Writing Ability
	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High
	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High
	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High	☐Low ☐Medium ☐High

ADDITIONAL INFORMATION: Please attach additional pages if necessary.

Please describe your experience, work or otherwise, which you feel may be helpful in the type of position in which you are interested.

What skills do you hope to gain or improve on during your experience?

How do you think that the Alamance County Health Department would contribute to your understanding of Public Health?

Explain any special skills or interests that you have that could contribute to your experience.

Why do you want to volunteer at this type of organization?

What are your goals or objectives in terms of professional or personal development and what role does the Alamance County Health Department play?

Certification

I certify the information given in this application is complete and correct. I further understand that discovering information to the contrary may be cause for re-determination of my volunteer, student, or internship assignments with the agency.

I certify that I am covered by an independent insurance carrier and that Alamance County will not be held responsible for any injuries that I may incur as a result of my volunteer, student, or internship services for the County.

Signature: ____ Date: _________________________________

If Volunteer is under 18 years of age:
I give permission for my child/ward to be a volunteer at this agency. I certify that my child/ward is covered by an independent insurance carrier and that Alamance County will not be held liable for any injuries that my child/ward may incur as a result of these volunteer, student, or internship services for the County.

Signature: ____ Date: _________________________________

STUDENT/INTERN CONSENT FORM

Print Name **Department/Program Assignment**

HOLD HARMLESS/RELEASE AGREEMENT

I understand and acknowledge that there may be a risk inherent in work associated with Alamance County Government, by agreeing to serve, the intern, in conjunction with the Educational Institution, hereby assumes all risks which may arise from providing these services. Interns, by agreeing to serve as such and in return for the provision of said opportunity, will indemnify and hold harmless the County of Alamance from any and all claims for liability, loss, injury, damages, costs or attorney's fees brought against Alamance County or any of its agents, employees, or commissioners arising out of any personal injury, wrongful death, or other damage sustained by a client or agent of the County due to services provided by the Intern. Any professional liability insurance under which said intern would be covered should be carried by the intern or in conjunction with the educational institution as required by their intern's placement with Alamance County.

Agreed between the parties on this the ______day of _____________, _______.

____
Student Intern Signature

CONSENT TO SEEK EMERGENCY MEDICAL CARE

This is to authorize the department to seek emergency medical care if, in the judgment of the staff it is needed, for a medical emergency. It is understood and agreed that the said staff, the department/program, and Alamance County will be held harmless for any and all results of the staff's efforts to obtain emergency medical treatment including any accident or injury while being transported.

Date__________________ Student/Intern ___________________________________

Date__________________ Witness___________________________________

Name of local physician ________________________ Phone______________________

Emergency contact person (local)_______________________________ Phone______________

CONSENT TO BE TRANSPORTED

It is understood and agreed that the said staff, the department/program and Alamance County will be held harmless in case of accident or injury to the student or intern while participating in program activities and while being transported to and from activities

Date__________________ Student/Intern ___________________________________

Date__________________ Witness___________________________________

If you are volunteering/interning as a part of a class or other requirement, please provide a brief description of the requirements.

Return to: **Jennifer Turner**
Human Resources Specialist
Alamance County Health Department
319 N. Graham-Hopedale Rd. STE B
Burlington, NC 27217
(336) 513-5512
jennifer.turner@alamance-nc.com

For ACHD Use Only

Student/Intern/Volunteer Placed: ☐Yes ☐No

Division Assigned/Placed: ____

Beginning Date: ________________________ To: _____________________

Location: ____

To Be Supervised By: ____

Tentative Hours: ____

Supervisor's Phone: ____