Summer Internship Program Application
June 15 – August 6, 2009

STUDENT INFORMATION (Please print or type)

HIGH SCHOOL: _____

NAME: _____ _____ _____
Last First M.I. Social Security # birth date

Address: _____

Email Address: _____ (most communications will be by email)

HOME PHONE: _____ ALTERNATE PHONE: _____

In Case of Emergency Contact: _____

Name of College/University attending in Fall 2009 and major: _____

Please attach copies of:
1. Academic record (official transcript, GPA, and class rank through fall semester, 2008.
2. All standard test scores (SAT and ACT preferred, PSAT scores not necessary).
3. Two (2) letters of recommendation from teachers, counselor, or principal.
4. Listing of extracurriculars, community service, and employment. Evidence of leadership is an important part of the selection criteria.
5. Student essay: Please state in one page or less why you would like to participate in the program, including how you decided on your first choice of clinical specialty. (We make every effort to match interns with their specialty of greatest interest.)

A maximum of 16 interns will be selected. INTERNS WILL WORK PART TIME FOR EIGHT WEEKS (20 hours per week for a maximum of 160 hours @ $7.30/hour). Each intern will be matched with a primary mentor in one of the following specialties but will also have opportunities to observe in other specialty areas. Please rank the following specialty areas with "1" being your first choice. (Areas are subject to availability.)

_____General Pediatrics
_____Pediatric Oncology
_____Molecular Cardiology Research
_____Neurology/Tuberous Sclerosis
_____Ped Surgery- Trauma Clinic
_____Autism Spectrum Disorders
_____Pediatric Endocrinology
_____Ped Surgery- Minimally Invasive, and Colorectal
_____Asthma Research, Epidemiology, and Biostatistics
_____International Adoption/ Infectious Diseases
_____Neurology Research (ADHD/Tourette's)
_____Pediatric and Adolescent Psychology
_____Pediatric Nephrology- Bioengineering
_____Pediatric Pulmonary/Sleep Medicine
_____Adult Internal Medicine (UC)
_____Adult Intensive/Critical Care Medicine (UC)

Parent/Guardian Permission: (Required for consideration)

I give _____ permission to participate in Cincinnati Children's Summer

Internship Program: _____ _____ _____
Full Name Signature Phone

I understand that to participate, **I MUST** attend orientation on June 15, 2009 and will agree to abide by all rules/policies and procedures explained to me during orientation.

Applicant Signature: _____ Date:_____

Please return to: Ms. Wanda Downton, Office of Career Development ML 7007, Cincinnati Children's Hospital, 3333 Burnet Ave., Cincinnati, OH 45229. **NO FAX'S WILL BE CONSIDERED. COMPLETE APPLICATION PACKETS MUST BE RECEIVED BY NOON, Monday April 13, 2009.** Questions – call (513) 636-9281.