

Program Area: _____

Due Date: _____

INTERNSHIP INFORMATION FORM

Each intern must complete this form and return it to the Office of Clinical Experiences (Speight 110 or fax 252-328-2361) *within the first 15 days of Senior I*. Once university supervisors are assigned, your supervisor will use this information sheet to contact you and/or your clinical teacher. This information* must be ACCURATE and LEGIBLE.

Intern's Contact Information:

First Name	Middle Name	Last Name	
Current Street Address	Current City	Current State	Current Zip Code
Permanent Street Address	Permanent City	Permanent State	Permanent Zip Code
Home Phone	Cell Phone	ECU email address	

Internship Placement Information:

School Assignment 1		School Assignment 2 <small>If appropriate (i.e. MIDG, Art, Music, TA, etc.)</small>	
School Name	School Address	School Name	School Address
Principal Name	School Phone Number	Principal Name	School Phone Number
Name of Clinical Teacher (CT)	CT Phone Number	Name of Clinical Teacher (CT)	CT Phone Number
CT Address	CT Email Address	CT Address	CT Email Address
CT Planning Time	CT has attended ECU CT Training? YES or NO	CT Planning Time	CT has attended ECU CT Training? YES or NO
Semester/Dates you will be assigned to this location:		Semester/Dates you will be assigned to this location:	

*Please notify the Office of Clinical Experiences of any changes to the above information immediately 252-328-6051.