Mt. Washington Pediatric Hospital

_____
Name

_____
College/University Attending

PRACTICUM APPLICATION

MT. WASHINGTON
PEDIATRIC HOSPITAL

1708 W. Rogers Avenue
Baltimore, Maryland 21209
(410) 578-8600

PROVIDING REHABILITATION
AND SPECIALITY CARE
FOR CHILDREN

NAME: _____
LAST FIRST MIDDLE

SOCIAL SECURITY NO.: _____

PRESENT ADDRESS: _____
STREET CITY STATE ZIP

E-MAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

HOW DID YOU LEARN OF OUR PROGRAM? _____

_____

IS YOUR INTEREST IN OUR PROGRAM IN CONJUNCTION WITH A SCHOOL OR COURT REQUIREMENT? ☐ YES ☐ NO IF YES, EXPLAIN FULLY: _____

_____

WHY DO YOU WANT TO COME TO MWPH? _____

_____

PREVIOUS EXPERIENCE WITH INFANTS/CHILDREN? _____

_____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

CONTACT PHONE: _____ CONTACT PHONE: _____

PLEASE NOTE: DO NOT LIST ANY ORGANIZATIONS BY NAME OR CHARACTER WHICH WOULD INDICATE THE RACE, SEX, CREED, COLOR, OR NATIONAL ORIGIN OF THE MEMBERS.

VOLUNTEER EXPERIENCE

		ORGANIZATION NAME	**SUPERVISOR NAME AND PHONE**	**DUTIES**	**HOURS PER WEEK**
FROM	TO				
FROM	TO				

AVAILABILITY AND PREFERENCES

PLEASE INDICATE THE DAYS AND TIMES YOU ARE AVAILABLE

☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY

☐ SATURDAY ☐ SUNDAY

☐ MORNING HOURS ☐ AFTERNOON HOURS ☐ EVENING HOURS

ESSAY QUESTIONS

Please answer the following questions:

How did you first become aware of or interested in child life?

What are you career goals?

What do you hope to gain from your Child Life practicum?

What strengths (skills and talents) would you bring to the child life practicum?

What are your expectations of a practicum program?

Please Read and Sign the Following Statement:

I hereby affirm that all statements and answers made in connection with this application, and any subsequent inquiries requested, are true and correct. It is understood and agreed that any willful misrepresentation by me will be sufficient cause for cancellation of the application and/or separation from the hospital's service at any time after I have begun. I give Mt. Washington Pediatric Hospital, Inc. permission to contact employers, supervisors and any other source concerning my activities, and I hereby release such reference sources from any liability for the consequences of information which they may release to Mt. Washington Pediatric Hospital, Inc.

Applicant's Signature: _____ Date: _____

Mt. Washington Pediatric Hospital in conjunction with applicable laws, does not discriminate on the basis of race, color, religion, national original, sex, age, physical or mental handicap or Veteran status in the selection and placement of volunteers, students or interns.