

**Children's Memorial Hospital  
Chicago, Illinois**

**Child Life and Art Therapy Internship Application**

Date \_\_\_\_\_ Applying for: Fall \_\_\_\_ Winter/Spring \_\_\_\_ Focus: Child Life \_\_\_\_ Art Therapy \_\_\_\_

Name \_\_\_\_\_ Phone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_

**Academic Background**

University/College \_\_\_\_\_ Dates Attended (Month/Year) From \_\_\_\_\_ To \_\_\_\_\_

Major \_\_\_\_\_ Minor/Areas of Emphasis \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree Earned \_\_\_\_\_ GPA \_\_\_\_\_

University/College \_\_\_\_\_ Dates Attended (Month/Year) From \_\_\_\_\_ To \_\_\_\_\_

Major \_\_\_\_\_ Minor/Areas of Emphasis \_\_\_\_\_

Graduation Date \_\_\_\_\_ Degree Earned \_\_\_\_\_ GPA \_\_\_\_\_

College Courses in Child Development, Child Life, Expressive Therapies or Related Medical Courses\*  
(Completed or in process of completion)

Course Title	Grade Earned
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____

\*Please include an official copy of your college transcripts

## Experience with Hospitalized Children

Child Life or Art Therapy Practicum\*  Yes  No (If no, please continue to next section)

Name of Institution \_\_\_\_\_ Department \_\_\_\_\_

Address \_\_\_\_\_

Dates (Month/Year) From \_\_\_\_\_ To \_\_\_\_\_ Hours per week \_\_\_\_\_ Total Hours \_\_\_\_\_

Briefly describe population and responsibilities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Practicum Supervisor \_\_\_\_\_ Telephone Number \_\_\_\_\_

\*Please attach a copy of your certificate of completion or a letter from your supervisor

Hospital or Health Care Volunteer Experience\*  Yes  No (If no, please continue to next section)

Did you work with a pediatric population?  Yes  No

Were you supervised by a Child Life Specialist?  Yes  No or Art Therapist?  Yes  No

Name of institution \_\_\_\_\_ Department \_\_\_\_\_

Address \_\_\_\_\_

Dates (Month/Year) From \_\_\_\_\_ To \_\_\_\_\_ Hours per week \_\_\_\_\_ Total hours \_\_\_\_\_

Briefly describe population and responsibilities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Volunteer Supervisor \_\_\_\_\_ Telephone number \_\_\_\_\_

\* Please attach a letter from your supervisor that includes a brief description of your experiences and hours completed.

Art Therapy/Child Life Work Experience  Yes  No (If no, please continue to next section)

Name of institution \_\_\_\_\_ Department \_\_\_\_\_

Address \_\_\_\_\_

Dates (Month/Year) From \_\_\_\_\_ To \_\_\_\_\_ Hours per week \_\_\_\_\_ Total hours \_\_\_\_\_

Briefly describe population and responsibilities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor \_\_\_\_\_ Telephone number \_\_\_\_\_

**Other Experience with Children, Adolescents and Families**

(do not repeat experiences listed previously on this application)

Name of Agency \_\_\_\_\_ Experience related to \_\_\_ work \_\_\_ school \_\_\_ volunteering

Address \_\_\_\_\_ Position/Title \_\_\_\_\_

Dates (month/year) From \_\_\_\_\_ To \_\_\_\_\_ Hours per week \_\_\_\_\_ Total hours \_\_\_\_\_

Briefly describe population and responsibilities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Agency \_\_\_\_\_ Experience related to \_\_\_ work \_\_\_ school \_\_\_ volunteering

Address \_\_\_\_\_ Position/Title \_\_\_\_\_

Dates (month/year) From \_\_\_\_\_ To \_\_\_\_\_ Hours per week \_\_\_\_\_ Total hours \_\_\_\_\_

Briefly describe population and responsibilities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor \_\_\_\_\_ Phone Number \_\_\_\_\_

Name of Agency \_\_\_\_\_ Experience related to \_\_\_ work \_\_\_ school \_\_\_ volunteering

Address \_\_\_\_\_ Position/Title \_\_\_\_\_

Dates (month/year) From \_\_\_\_\_ To \_\_\_\_\_ Hours per week \_\_\_\_\_ Total hours \_\_\_\_\_

Briefly describe population and responsibilities \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor \_\_\_\_\_ Phone Number \_\_\_\_\_

**Professional, School and Community Involvement**

List organizations you are currently or recently involved in \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**References**

Please provide three references, including at least one professor and one professional who has seen you interact with children. References can include professionals previously mentioned on this application.

Name \_\_\_\_\_ Organization/Agency \_\_\_\_\_  
Agency address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Daytime phone number \_\_\_\_\_

Name \_\_\_\_\_ Organization/Agency \_\_\_\_\_  
Agency address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Daytime phone number \_\_\_\_\_

Name \_\_\_\_\_ Organization/Agency \_\_\_\_\_  
Agency address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Relationship to you \_\_\_\_\_ Daytime phone number \_\_\_\_\_



## College Enrollment Information

Will you be using the internship to complete college credits? \_\_\_\_ Yes \_\_\_\_ No

If yes, what college? \_\_\_\_\_

College site supervisor name \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

### Please Enclose

- \_\_\_\_ A copy of your official transcripts
- \_\_\_\_ Practicum certificate OR letter from your practicum supervisor, if applicable
- \_\_\_\_ Letter from your volunteer supervisor, if applicable
- \_\_\_\_ A copy of your current resume
- \_\_\_\_ Non-refundable fee of \$10, made payable to Children's Memorial Hospital. Do not send cash.

I confirm that the information provided in the application is true to the best of my knowledge. I further understand that any false statements on the application shall be sufficient cause for rejection for this internship or immediate discharge when discovered.

I hereby authorize my former supervisors and references to release information regarding my past experiences to assist this committee in determining my suitability for the internship.

Applicant's signature \_\_\_\_\_ Date \_\_\_\_\_

Please return completed application and materials to:

Victoria Storm  
Manager, Children's Services, Child Life Team  
Children's Memorial Hospital  
2300 Children's Plaza, Box 31  
Chicago, IL 60614

Please direct any question to 773.880.3118.

Children's Memorial Hospital's internship selection committee does not discriminate on the basis of race, creed, ancestry, color, religion, sex, national origin, age, marital status or disability. We reserve the right to not offer the internship every semester.