

# STUDENT NURSE INTERN APPLICATION

Please complete the following and **December 4, 2009**, via fax to (320) 656-7022 or to address listed on bottom of next page. Also please submit a resume that includes all health care employment experience and volunteer activities.

Name: \_\_\_\_\_ School Attending: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

List up to 4 areas of interest in order of preference (1-4):

- |  |   |
|--|---|
| <input type="checkbox"/> Behavioral Health/Mental Health | <input type="checkbox"/> Oncology/Cancer Program            |
| <input type="checkbox"/> Center for Surgical Care        | <input type="checkbox"/> Orthopedics/Neurology              |
| <input type="checkbox"/> Emergency Trauma                | <input type="checkbox"/> Outpatient Services                |
| <input type="checkbox"/> Family Birthing Unit            | <input type="checkbox"/> Pediatrics/Neonatal Intensive Care |
| <input type="checkbox"/> Hospital House Float Pool       | <input type="checkbox"/> Rehabilitation                     |
| <input type="checkbox"/> Intensive Care                  | <input type="checkbox"/> Surgery/Operating Room/PACU        |
| <input type="checkbox"/> Kidney Dialysis                 | <input type="checkbox"/> Surgical                           |
| <input type="checkbox"/> Medical                         | <input type="checkbox"/> Telemetry/Cardiac Care Unit        |

List clinical rotations you have had or will be having:

Sophomore Year \_\_\_\_\_

Junior Year

Fall \_\_\_\_\_

Winter \_\_\_\_\_

Spring \_\_\_\_\_

Senior Year

Fall \_\_\_\_\_

Winter \_\_\_\_\_

Spring \_\_\_\_\_

(OVER)

I have requested letters of recommendation from the following nursing instructors:

1. Name \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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2. Name \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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I have requested a letter of recommendation from my previous work place/experience:

1. Name \_\_\_\_\_ Title \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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When will you be available for an interview?

\_\_\_\_ Week of December 14, 2009      \_\_\_\_ Week of December 21, 2009      \_\_\_\_ Week of January 4, 2010

I authorize St. Cloud Hospital to verify my academic status at the conclusion of my junior year.

Signature \_\_\_\_\_ Date \_\_\_\_\_

St. Cloud Hospital, Human Resources Department  
1406 Sixth Avenue North, St. Cloud, Minnesota 56303-1901  
Fax 320-656-7022, Phone 800-835-6608  
St. Cloud Hospital operates under the auspices of the local Catholic Church of St. Cloud.