The St. Cloud Hospital
Dietetic Internship
Supplemental Application

Name: _____ _____ _____
First Middle Last

Email Address: _____

Track/Concentration Preference (please circle all that apply):

- **MNT Concentration**
  - **Full Time**
  - **Part Time**
- **Community Nutrition Concentration**
  - **Full Time**

Check Number (for application fee): _____