West Central Health District
2100 Comer Avenue
Columbus, Georgia 31902
706-321-6300

Internship Application

Personal Information

Name_____Cell Phone_____

Address_____ Alternate Phone_____

_____Email_____

Emergency Contact_____Phone_____

Relationship_____ Alternate Phone_____

Skills_____

_____

Internship you are applying for: _____

What times are you available?

Mon_____Tues_____Wed_____Thurs_____Fri_____

Would you be available to work an event on a Saturday? _____ Time_____

Which county locations could you work in? _____

Education Information

School_____Semester/Quarter_____

Address_____City/State/Zip_____

Major/Minor _____Graduation date_____

Advisor_____Dept._____

Email_____Phone_____

Requested Internship start date _____ End date_____

Semester/Quarter start date _____End date_____

Hours required to complete_____

Employment

Present/Last Employer_____ Position_____

Address _____FT/PT _____

References (No Relatives)

Name_____Phone_____

Name_____Phone_____

Release & Agreement

I have agreed to participate in the Intern Program at the West Central Health District, Columbus Health Department and understand that I will not be paid for my services and will not be covered by Workers' Compensation insurance, as are employees of the West Central Health District and Columbus Health Department.

As a participant in the Intern Program, I release the West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents, other interns and volunteers from all liability of any kind whatsoever including, but not limited to, claims, demands, actions or causes which may arise out of my participation and waive all rights which I may have against the West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents, other interns and volunteers .

Furthermore, I agree that I will not assist any other person or entity in making a claim or bringing a legal action against the West Central Health District, Columbus Health Department, the Georgia Department of Human Resources and their officials, employees, agents, other interns and volunteers for any matter which might arise out of my participation in the Intern Program.

I understand that my attendance and involvement in the Intern Program is strictly voluntary and that I am participating at my own risk.

I have read and agree to the foregoing terms and conditions of this Release & Agreement.

_____

Signature Date

_____

Advisor/Department Head Signature Email Address Date

****ALL APPLICATIONS MUST BE SIGNED BY ADVISOR OR DEPARTMENT HEAD****

(4/2025)

Submit