TRAINING INSTITUTE

VCBH Clinical Training

Mental Health Associate Internship

Applicant Name: _____ Date: _____

Street Address: _____

City / State / Zip Code: _____ Drivers License #: _____

Home Phone: _____ Cell phone: _____ Email: _____

Contact in Case of Emergency: _____ _____
NAME RELATIONSHIP

If currently employed please list name of employer: _____

Work hours and days: _____ Work Phone: _____

SCHOOL AND PROGRAM INFORMATION

School Name (if currently enrolled) _____ Major: _____

Year in program: ☐ Junior ☐ Senior ☐ other_____ ☐ N/A Expected Graduation Date: _____

Contact person at school (if requesting academic credit for internship):

_____ _____ _____
NAME TITLE PHONE NUMBER

Desired start date for internship: ☐ Fall Semester _____ (year) ☐ Spring Semester _____ (year)
List days and times you are available for an internship:

_____

_____ Number of hours/week: _____

PREFERENCES, INTERESTS, AND EXPERIENCE

Populations of Interest:
☐ children and families ☐ adults ☐ older adults ☐ transitional aged youth (18-25 years old)
☐ adolescents in juvenile justice system ☐ forensic population (adults) ☐ alcohol and drug treatment

Preferred Location(s) or area(s):
☐ Ventura ☐ Oxnard ☐ Thousand Oaks ☐ Simi Valley ☐ Santa Paula/Fillmore

Bilingual? ☐ No ☐ Yes If yes, language(s) spoken: _____

Do you have any specific learning objectives for this internship?

_____

_____

_____

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Do you have any previous work experience or volunteer experience in an agency or organization that provides treatment for mental health issues or treatment of drug and alcohol addiction?

☐ No ☐ Yes Name of Agency _____

Types of duties performed:_____

_____

_____

List any unique skills or experiences that would enhance or contribute to your participation in the internship:

_____

_____

Highlight any previous experiences in working with culturally diverse populations: _____

_____

_____

ADDITIONAL INFORMATION

Do you have any restrictions or limitations that we should be aware of? ☐ No ☐ Yes

If yes, please explain: _____

_____

_____

Please describe any other important additional information that was not mentioned previously:

_____

_____

_____

REFERENCES (please provide 1 letter of recommendation with application)

Name: _____ Agency if applicable: _____

Phone: _____ Relationship: _____

HEALTH AND BACKGROUND SCREENING

- All employees, volunteers, and students are required to be screened annually for tuberculosis. You have an option of having a tuberculin skin test through the departments employee health services, at no cost to you, or you can opt to have the test done by your personal physician.
- All employees, volunteers, and students are required to complete a background clearance. This is conducted through our department, at no cost to you. Any offer of an internship is contingent upon completion of the background clearance.

The above information is accurate and correct to the best of my knowledge

_____ _____

SIGNATURE DATE

Return the completed application with a cover letter, copy of your resume and 1 letter of recommendation to:

Carla Cross, LMFT, ATR-BC, Internship and Clinical Training Manager

1911 Williams Drive, Suite 200, Oxnard, CA 93036

Phone: (805) 981-4221 | Fax: (805) 981-6838 | Email: Carla.cross@ventura.org

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