**Oneida County**

**Health Department**

**Internship Interest Form**

**Student & University Information**

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

Degree Sought:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anticipated Graduation Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Internship (Required Hours):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Desired Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

University Advisor Name and Contact Info: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Oneida County Health Department? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCHD Requirements**

We are pleased with your interest in working with Oneida County Health Department! We value student interns and want you to have the most rewarding experience possible. Please review and submit the required documents below to help us find the right fit for you in our department.

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| --- | --- |
| **Item to Review** | **Date Reviewed** |
| 1. Oneida County Health Department Website

 <http://oneidacountypublichealth.org/> |  |
| 1. Oneida County Community Health Improvement Plan (CHIP)

 <http://oneidacountypublichealth.org/?p=454> |  |
| 1. Oneida County Annual Report

 <http://oneidacountypublichealth.org/?p=213> |  |
| **Please submit a one page summary with the following:** | **Included** |
| 1. Professional and Career Goals

*Why are you exploring the public health field?* *Where do you see yourself in 5-10 years?* | Y / N |
| 1. Internship Expectations

*What do you plan to get from your internship experience?* | Y / N |
| 1. Areas of Interest at OCHD

*Which programs or departments would you like to work with and why?* | Y / N |
| **Resume (Optional)** | Y / N |
| **References (Optional)** | Y / N |

**Please Mail, Fax or Email Form to:**

Oneida County Health Department

100 W. Keenan Street

Rhinelander, WI 54501

Fax: (715) 369-6112

Email: [ochd@co.oneida.wi.us](file:///%5C%5Cocfsoch01%5Cgroups%5CPHShare%5CADMINISTRATION%5CInterns%5CForms%5Cochd%40co.oneida.wi.us)