

NORFOLK STATE UNIVERSITY
School of Education
Office of Clinical Experiences and Student Services (OCESS)

<i>For Office Use Only</i>
Major: _____
No. of Hours Required: _____
Placement Site(s): _____
Contact Name: _____
Date: _____

Rehabilitative Counseling Graduate Internship Application

(*SEMESTER: When do you plan to begin the Internship?)

Major: _____	*Semester: _____	*Year: _____			
Applicant's Name: (Please Type)					
	Last	First	MI	Student ID	

CERTIFICATION INSTRUCTIONS:

This certification/departmental endorsement is to be completed by the applicant, official representative(s) of the School of Education, and the department from which the applicant is a major. All applications will be maintained by the Office of Clinical Experiences and Student Services (OCESS). Make copies of documents before submitting them to the OCESS. Personal copies of documents are the responsibility of the applicant. PLEASE type responses in blanks where required.

APPLICANT CERTIFICATION:

I further understand that failure to comply with the agency or field placement guidelines or substandard performance in the Internship experience may result in dismissal from the Internship program.

I fully understand that proof of successful completion of the VCLA, VRA, PRAXIS Core, or SLLA, if applicable, Child Abuse Recognition Certificate, School Division's Placement Request form, the background verification form, tuberculosis/chest x-ray and other required documents are integral to this application process and I will comply as requested. See <http://www.nsu.edu/education/OCESS/forms>

I certify that all information given is correct, and that I have completed all program requirements for admission to the clinical experience. I will be eligible to begin the Internship in the upcoming semester.

 Applicant's Signature (Date)

DEPARTMENT ENDORSEMENT

On the basis of my knowledge of the applicant's preparation and characteristic performance in the subject matter area of _____, I ___ DO ___ *DO NOT endorse this applicant as a worthy and promising candidate for the Practicum during the upcoming semester.

Department Head , please indicate the University Supervisor:		Course number(s)

Signed by (Advisor):	Date:
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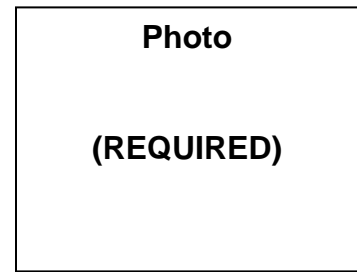
Approved by (Major Head of Department):	Date:
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*Comment(s)

[Type text]

NORFOLK STATE UNIVERSITY
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Application for Graduate INTERNSHIP, p.2



Please check applicable program:

MA DEGREE <input type="checkbox"/>	CERTIFICATION ONLY <input type="checkbox"/>	Pre-ECE <input type="checkbox"/>
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SECTION I--Personal Data				
Date of Birth: (MM/DD/YY)	Gender	Ethnicity		
Applicant's Name: (Please Type)	Last	First	Middle	Student ID
	Address: (Local)		State	Zip Code
Street		City	State	Zip Code
Telephone: (Local)	(Home)	(Work)	(Cellular)	Email
	Address: (Permanent)		State	Zip Code
Street		City	State	Zip Code
Telephone: (Permanent)	(Home)	(Work)	(Cellular)	Email
	Emergency Contact: (Local-other than where you reside)		(Relationship)	(Phone)

SECTION II - - Education History				
Name of College attended other than NSU:				
Degree Received (BA, BS etc., and DISCIPLINE)			Graduation Date:	
~Norfolk State University Information~				
Advisor:				
Major:		Emphasis:		Graduation Date:
Special Education:	General Curriculum	<input type="checkbox"/>	Adapted	<input type="checkbox"/>
		<input type="checkbox"/>		<input type="checkbox"/>
(PRACTICUM)				
Date Admitted to Teacher Education: (MM/DD/YY):				
PRAXIS Core Test Score:			SLLA Test score:	

SECTION III - - Teaching Related Experience (other than ECSE)				
Teacher Assistant	<input type="checkbox"/>	School		How many years?
Substitute Teacher	<input type="checkbox"/>	School		How many years?

SECTION IV - - Teaching Status					
Do you have at least one year experience as a contracted teacher?				*YES <input type="checkbox"/>	NO <input type="checkbox"/>
If "YES", complete this row for all experiences.	School Name:		City:	Beginning Year?	

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Application for Internship continued

SECTION IV - - Describe your philosophy of education leadership/teaching.

Date

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Application - Tuberculosis Test

Last Name _____	First Name _____	MI _____
SSN _____	Age _____	DOB (MM/DD/YY) _____
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Race _____
Street Address, City, State & Zip _____		
Telephone: <i>Home:</i> _____ <i>Work:</i> _____		
<i>Cellular Phone:</i> _____ email: _____		

Requested for (please check one) Fall _____ Spring _____ Year _____
On the basis of chest X-ray, test, and/or examinations, I hereby certify that the student identified at the top of this page is diagnosed to be free of communicable tuberculosis as of the date below.
I am a licensed physician in _____ (State or District), United States of America
Date: _____ Signed: _____
Address: _____
Telephone: ____ (____) _____
Virginia State Law requires the education candidate to return this TB Certification to the Office of Clinical Experiences and Student Services prior to the field experience. The test is to be effective through the entire field experience.

Norfolk State University
School Education
Office of Clinical Experiences and Student Services
Application - Background Verification Form

Addendum to Field Experience and Clinical Practice Applications

All applicants are required to read and verify the following statements when submitting requests for field placements:

I have not been convicted of a violation of law other than a minor traffic violation.
I do not have any criminal charges or proceedings pending against me.
I do not have a felony, misdemeanor, or other offense for drugs, sexual abuse, and/or child abuse.
I understand that if the above mentioned conditions are violated, it can result in cancellation of the field experience.

If you are able to verify the above statements when submitting requests for field placements, please sign below:

Print Name	Signature	Date

If you are unable to verify one or more of the above statements, please give a brief explanation below and schedule a conference with the Director, OCESS. Please sign below the box:

Student Comments:

Print Name	Signature	Date

