



DIETETIC INTERNSHIP APPLICATION

All information on this application must be typed. Additional pages may be added.

Name of Applicant: (Last) (First) (Middle/Maiden)

Present Address: (Street) (City) (State) (Zip Code)

Phone Number: ()

Permanent Address: (Street) (City) (State) (Zip Code)

Phone Number: ()

Work Phone Number: () E-mail Address:

Social Security Number:

Foreign Applicants: Designate Immigration Status: Expiration Date / /

Actual or Expected Date Baccalaureate Degree Will Be/Was Conferred: / /

Actual or Expected Date Didactic Program in Dietetics Requirement Will Be/Was Completed: / /

Education (List all colleges and universities attended with most recent listed first.):

Table with 4 columns: SCHOOL, ADDRESS, DATES, DEGREE



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WORK EXPERIENCE RELATED TO DIETETICS IN THE PAST FIVE (5) YEARS: List all work experience related to the field of dietetics, beginning with most recent experience. Indicate experience as paid or volunteer.

PLACE OF EMPLOYMENT	NAME & TITLE OF SUPERVISOR	DATES	HRS./WK.	PAID/VOL.	POSITION, TITLE & RESPONSIBILITIES

OTHER WORK EXPERIENCE IN THE PAST FIVE (5) YEARS: List all other work experience, beginning with most recent experience. Indicate experience as paid or volunteer.

PLACE OF EMPLOYMENT	NAME & TITLE OF SUPERVISOR	DATES	HRS./WK.	PAID/VOL.	POSITION, TITLE & RESPONSIBILITIES

HONORS, EXTRACURRICULAR ACTIVITIES: List organizations, appointed or elected offices, scholarships and honors received.



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RECOMMENDATIONS: List the names of all individuals who will complete your Recommendation Forms. For "Type," indicate whether the recommendation is Academic, Professional – Employment or Personal in nature.

Table with 4 columns: NAME, TYPE, ADDRESS, PHONE. Rows 1, 2, 3.

SUBMIT A TYPEWRITTEN LETTER TO THE SELECTION COMMITTEE AS PART OF THIS APPLICATION. Use this opportunity to tell us how you plan to succeed in completing this program. Include answers to these questions:

- 1. How will you meet your expenses?
2. Do you have a reliable means of transportation?
3. Where will you live?
4. In what ways will your family and/or employer support you?
5. What other activities will demand your time?

NOTE: If you have ever accepted a position in another dietetic internship (or AP4 program), include information concerning whether or not you completed the program. If you did not complete the program, explain why. If you did complete the program, explain your reasons for applying for the North Oaks Dietetic Internship.

Please feel free to include any other information that you feel is important. The letter must be at least two, but not more than three, pages in length and double-spaced.

HAVE YOU EVER BEEN DISCHARGED FROM A JOB OR FORCED TO RESIGN? [] Yes [] No
If "yes," explain briefly in your letter.

HOW MUCH TIME HAVE YOU LOST FROM WORK AND/OR SCHOOL THROUGH PERSONAL ILLNESS IN THE LAST THREE (3) YEARS? _____

HAVE YOU EVER BEEN CONVICTED OF A FELONY, A VIOLATION OF THE NARCOTIC DRUG LAWS OR LAWS RELATING TO SEXUAL OFFENSES? [] Yes [] No

An original signature (no photocopies) is required on Page 4 of 4 following these statements. I understand that the North Oaks DI reserves the right to require its dietetic interns to submit to blood tests or urinalysis for alcohol or drug testing. I understand that refusal to submit to urinalysis or blood testing when requested to do so may result in termination of my appointment.

I understand that the North Oaks requires its interns to have a physical examination; tuberculin skin test and/or chest X-ray if the test is/has been positive; blood tests: HEME 8, Hepatitis Screen, RPR – if positive, then more specific tests will be required; Rubella Titre, or proof of a positive Rubella Titre, or proof of having received two (2) MMR vaccines, or a written statement from a physician that the intern has had Rubella.

Note: These tests are not required prior to acceptance into this program. Those who accept placement in the North Oaks Health System Dietetic Internship are responsible for the cost of required physical examination components.



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I certify that the information that I have provided in this application is true and accurate and recognize that any false or incorrect statements made herein will be grounds for my dismissal from the internship. I understand that I must provide an original copy of a signed Verification Statement* substantiating completion of (or Declaration of Intent to Complete) Degree and ADA-Approved Minimum Academic Requirements in addition to current official transcripts as part of this application. I also understand that, if I request that application materials be returned to me, the recommendation forms will not be included in what is returned. All requests for the return of application materials must be made prior to March 31, 2008.

*Note: I understand that a signed Verification Statement is required prior to enrollment.

Signature

Date

Mail to the applicable address: Regular Mail
North Oaks Health System
Nutritional Services Department
P.O. Box 2668
Hammond, LA 70404
ATTN: Virginia Pelegrin, MPH, LDN, RD
Internship Director

Overnight Mail/Shipment
North Oaks Medical Center
Nutritional Services Department
15790 Paul Vega, MD, Drive
Hammond, LA 70403
ATTN: Virginia Pelegrin, MPH, LDN, RD
Internship Director

For more information, please call: (985) 230-6606.

Note: This form must be postmarked on or before February 8, 2008. Overnight mail/shipment is recommended for application components sent on or near the deadline.