

Levine Children's Hospital Child Life Practicum Application

In order to be considered for placement you must submit the following application materials to:

Molly Whitt
Child Life Practicum Coordinator
Levine Children's Hospital
1000 Blythe Blvd., Room 2034
Charlotte, NC 28203

____ Completed Application

____ Resume

____ Volunteer verification form (please include one per facility) total 50 hours

____ Unofficial transcripts from all academic institutions you have attended (student copy is acceptable)

____ Child Life Council relevant coursework list

____ Two sealed and initialed letters or recommendation (one should be from a professional who has observed you working with children)

____ Signed application checklist

By signing, I indicate that I have reviewed and met the application requirements. I am submitting all necessary documentation to be considered for a child life practicum experience at Levine Children's Hospital.

Signature: _____

Date: _____

**Levine Children's Hospital
Child Life Department
Practicum Applicant Information Sheet**

Please Type

Applying for Year _____ **Summer**

Personal Information

Name			
Present Address:			
Permanent Address:			
E-mail Address:			
Phone:			
Social Security #			

Emergency Contact

Name:			
Relationship:			
Address:			
Best contact #		Alternate #	

University Affiliation

University Name			
Address			
<u>Advisor Information</u>			
Name			
Phone			
E-mail Address			

Academic Information

Please list information for all universities and colleges attended

University Name			
Major			
GPA – Cumulative:		GPA in Major	
Graduation date:			

____ Bachelors ____ Masters

University Name			
Major			
GPA – Cumulative:		GPA in Major	
Graduation date:			

____ Bachelors ____ Masters

University Name			
Major			
GPA – Cumulative:		GPA in Major	
Graduation date:			

____ Bachelors ____ Masters

What days and times are you available to fulfill your practicum hours? (Please keep in mind we will offer shifts Monday-Friday depending on staff availability)

What other commitments will you have during your practicum?

I understand it is the sole responsibility of the applicant to confirm receipt of application packet. I understand if my application packet is incomplete, I will not be considered for the practicum program.

Date

Signature

**Levine Children's Hospital
Child Life Department
Practicum Questionnaire**

(These need to be typed on a separate piece of paper. Please limit answers to 200 words.)

1. Describe how you became interested in pursuing Child Life?

2. What strengths (skills and talents) would you bring to the child life practicum?

3. What are your challenges related to working with children?

4. With what age group or medical population do you prefer to interact with and why?

4. What are your expectations of a practicum program?

Levine Children's Hospital
Child Life Department Practicum Program
Child Life Council Relevant Coursework List
(All courses listed must be present on unofficial transcripts)

Course Number and Title <i>(i.e. Child Development)</i>	Where <i>UNCC</i>	Year <i>2017</i>	Term <i>Spring</i>	Grade <i>A</i>
1.				
2.				
3.				
4.				
5.				

**Supervised Hours Working with Children
Verification Form**

(Applicant: This form is to be completed by all places from which you are submitting hours.)

I confirm that (applicant) _____ has
completed _____ hours at (Institution) _____ in
(location) _____ working with:

(Type of experience – check one)

____ Working with children who are physically well / Working with typically developing children (25 hours)

____ Working with children in a healthcare or stress-related environment/ Working with children with special needs (25 hours)

The applicants experience consisted of the following experiences (list typical types of interactions with children):

Signature/Credentials: _____

Printed Name: _____

Title: _____

Date: _____

Phone Number: _____