TriHealth
Fitness & Health Pavilion

# Intern Application

*TriHealth is an affirmative action/equal employment opportunity employer. Discrimination because of race, color, religion, sex, handicap, sexual orientation or national origin is prohibited.*

***In order to be considered for an internship, you must submit a completed application form along with a cover letter, resume, and two letters of recommendation.***

Name:_____Last Four Digits of SS#: XXX-XX-_____

Local Address: _____

Local Phone:_____Email:_____

Permanent Address:_____

Permanent Phone:_____ Date of Birth:_____

University:_____

University Address:_____

University Intern Coordinator:_____

Intern Coordinator Phone:_____Email:_____

Academic Major: _____

Does your University provide liability insurance: YES___ NO ____

## Internship Interested In:

___ Fitness Management/ Personal Training

___ Medical Integration

___ Spa Management

___ Aquatics

___ Business Operations Management

____ Child/Adult Recreation Program Management

____ Group Fitness

____ Marketing/Sales

____ Business Management/ Health Care Administration

## Internship Period Applying For:

___ Spring (January – April) __ Summer (May – August) __ Fall (September – December)

## Education

High School:_____Date of Graduation:_____

High School City/State: _____

College:_____Date of Graduation: _____

College City/State:_____

Internship Goals:_____

_____

_____

Career Goal:_____

_____

_____

_____

**Employment History (include paid, volunteer and intern positions)**

Employer:_____Phone:_____

Address:_____

Supervisor Name/Title: _____

Position Title:_____Start Date:_____End Date:_____

Description of Duties:_____

Employer:_____Phone:_____

Address:_____

Supervisor Name/Title: _____

Position Title:_____Start Date:_____End Date:_____

Description of Duties:_____

Employer:_____Phone:_____

Address:_____

Supervisor Name/Title: _____

Position Title:_____Start Date:_____End Date:_____

Description of Duties:_____

I hereby acknowledge that the information submitted on this form is truthful to the best of my knowledge. A also acknowledge that any information provided with this application with be kept on file for future reference.

_____ _____

Applicants Signature Date

*Return Completed Application to:*

**LaShaunda Jones**
**TriHealth Fitness & Health Pavilion**
**6200 Pfeiffer Rd.**
**Cincinnati, OH 45242**
**513 246 2647 Phone / 513 985 0918 Fax/ 513 852 3846 EFax**
**lashaunda_jones@trihealth.com**