



Session(s) applying for: ☐ Summer ☐ Fall ☐ Winter/Spring Year: \_\_\_\_\_

Is this Practicum for course credit? ☐ Yes ☐ No If yes, number of hours required: \_\_\_\_\_

If yes, course signup deadlines which must be met for your school: \_\_\_\_\_

**Availability:** Beginning and ending dates \_\_\_\_\_

Indicate days of the week and times of the day when you will be available to complete your practicum hours (options are Monday through Friday between the hours of 9:00am and 5:00 pm)

## Child Life Services Practicum Application

### Personal Information

Hospital policy requires individuals having contact with patients be 18 years of age or older. If you are 15-17 years of age please contact us to discuss alternative opportunities.

Full Name: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Primary Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Birth date: \_\_\_\_\_

### Emergency Contact Information

Full Name: \_\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

\_\_\_\_\_ *City State ZIP Code*

Primary Phone: ( ) \_\_\_\_\_ Alternate Phone: ( ) \_\_\_\_\_

Relationship: \_\_\_\_\_

### Education

College/University: \_\_\_\_\_

Major: \_\_\_\_\_ Minor: \_\_\_\_\_

G.P.A.: \_\_\_\_\_ Graduation Date: \_\_\_\_\_

Academic Advisor: \_\_\_\_\_

Advisors' Contact Information: ( ) \_\_\_\_\_ e-mail address: \_\_\_\_\_

List courses taken which are relevant to child life practice (include date and grade for each):

_____	_____
_____	_____
_____	_____
_____	_____

## Experience

List child related hospital, practicum, volunteer and job experiences which have prepared you for this practicum:

Dates	Position Held	Institution/Location	Number of Hours

Non-child related experiences which have prepared you for this practicum:


## Questions

We ask that you respond on this application form and in the space provided. If there is insufficient space for you to complete your response to a specific question, continuing your response on an attached page is acceptable.

1. How did you learn about child life at this hospital: \_\_\_\_\_

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2. Describe your strengths and weaknesses in working with children: \_\_\_\_\_

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3. Describe personal experiences you have had with hospitals/health care centers and how this affected your attitude towards hospitals/health care centers:

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4. Describe your reactions to illness/accidents in the past: \_\_\_\_\_

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5. Briefly describe what you think you will experience in this Child Life Practicum: \_\_\_\_\_

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6. Describe briefly how you think you would handle your feelings if you were working with: an acutely ill child; a chronically ill child with a life threatening illness; a terminally ill child:

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7. Indicate, in your opinion, what hospitalized children need most: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Indicate what you hope to gain from this experience: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### References

Excluding family members, friends or a significant other, list the names and contact information for two individuals whom we may contact. Professional references should have known you for more than one year.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_

I understand that successful completion of the practicum includes working a minimum of 100 hours (approximately 8-10 hours per week for one semester) under the supervision of a child life specialist.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Additional Personal and Professional Information

Do you have relatives or friends currently employed with Children's Hospital? \_\_\_\_\_

If yes, please give their names and relationship: \_\_\_\_\_

Have you ever been discharged (fired) or requested to resign from a former position? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been convicted of any offense other than a traffic violation? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### General Information and Authorization for Release

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I, the undersigned, certify that I have read, personally completed, and fully comprehend this form in its entirety, and the information herein provided is true and complete without omission, to the best of my knowledge. I understand that should any statement I have made prove false, misleading, misrepresented or erroneous, my application may be rejected, or if participating in a practicum, I may be discharged immediately from Children's National (CN). In submitting this application I further understand that it becomes the property of Children's National and will not be returned. This application will only be considered complete if signed below on the appropriate line.

I understand that a successful applicant must meet the requirements of the position, which may include successful completion of oral or written examinations. Successful applicants will receive conditional offers to participate in a practicum, subject to satisfactory completion of a background investigation, and a medical examination. I agree to take any post-conditional offer and medical examination required by the hospital. I also agree to comply with all CN policies and procedures.

I acknowledge and agree that any information or references provided to or received by CN are confidential between the reference and CN and that I will not have access to reference information. I further acknowledge that CN informed me that practicum offers made are contingent on receipt of references and /or verification of information I have provided about my work history.

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Signature of Applicant

Date

**Email Completed Application to:**

**Kelly Beck, CCLS**

**[kbeck@childrensnational.org](mailto:kbeck@childrensnational.org)**

**Subject line: Practicum Application**