Internship/Residency HCAD 5399 Authorization

Master of Science in Health Care Administration
College of Business (COB)
(Submit if you have 24 hours of graduate work completed.)
PLEASE COMPLETE AND SUBMIT BEFORE YOU BEGIN YOUR INTERNSHIP.

Organization ____

Supervisor/Preceptor ________________________________ Title:____________________________

Address ____________________________________ City _______________ State ___ ZIP _________

Phone Number _____________________FAX Number ___________ email _____________________

Intern/Resident_______________________________________ Project Area: ____________________

Address ____________________________________ City _______________State ___ ZIP __________

Home Phone ________________________Work Phone _______________ email __________________

Internship Dates: Start ____________ End ___________ (**240 Contact Hours**)

Scheduled Duties and/or responsibilities:

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Training Opportunities:

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Tentative Work Schedule:

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____ _________________________
Internship Site Supervisor/Preceptor Date

____ _________________________
Student/Intern/Resident Date

____ _________________________
Internship Coordinator or Program Director Date