Clinical/Internship Experience

FOR APPLICANT TO COMPLETE BEFORE MAILING TO SCHOOL

LAST NAME	FIRST NAME	MIDDLE NAME

DATE OF BIRTH (MM/DD/YY)	FILE NUMBER

INSTITUTION/SCHOOL ATTENDED: _____

DATES OF ATTENDANCE (MM/DD/YYYY) FROM: _____ TO: _____

NAME WHILE ATTENDING (*if different from name above):*

_____

LAST FIRST MIDDLE

I hereby authorize the release of my educational records to FACTS.

_____

APPLICANT SIGNATURE

_____

DATE

FOR INSTITUTION TO COMPLETE BEFORE SUBMITTING TO FACTS

Directions for school: Mail completed form and send along with clinical internship information to :

FACTS
1930 Winter Street
Kingsburg, CA 93631

Name of applicant:: _____
Last First Middle

Name of degree awarded: _____

Number of clinical internship hours completed: _____

Clinical/Internship Experience

1. Placement	# of hours	Starting date	Ending date
1. Placement	# of hours	Starting date	Ending date
1. Placement	# of hours	Starting date	Ending date
1. Placement	# of hours	Starting date	Ending date
1. Placement	# of hours	Starting date	Ending date
1. Placement	# of hours	Starting date	Ending date
1. Placement	# of hours	Starting date	Ending date

Name of school/institution: _____

Name of official filling out form: _____

Address of Institution: _____
STREET *CITY*

_____
STATE *ZIP CODE* *COUNTRY*

Phone Number: _____

Clinical/Internship Experience

SIGNATURE AND SEAL REQUIRED FOR COMPLETION OF THIS FORM

I certify that these responses are complete and accurate to the best of my knowledge. In witness, I hereby set my hand and seal of this institution on this _____ day of _____, 20_____.

Name of official: _____

Official's signature: _____