



# INTERNSHIP APPLICATION

*Thank you for your interest in the Park Equine Hospital Internship program!  
A complete application packet includes the following: **this form, curriculum vitae, a letter of intent, and letters from three professional references.** (Upon acceptance, the applicant must provide **ORIGINAL OFFICIAL TRANSCRIPTS** from the veterinary school from which their degree was obtained.) Applications that are missing information or the required supporting documentation are deemed incomplete and will not be considered.*

## IDENTIFICATION INFORMATION

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

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

City, State, & Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

Date of Birth (MM/DD/YYYY): \_\_\_\_\_ Circle One:      MALE      FEMALE

Current School/University: \_\_\_\_\_

School/University Address: \_\_\_\_\_

Have you been injured or do you have any injuries (hip, back, knee, wrist, etc.) that would hinder your participation in this program? Do you have any allergies (hay, straw, animals, dust, etc.) If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Our internship program starts in June and ends the following June; if you anticipate needing accommodations with this schedule, please check:

Please rank your interest in the following rotations: 1 being your favorite and 3 being your least favorite.

Ambulatory       Surgery       Internal Medicine

Please rank your interest in the following subjects: 1 being your favorite and 8 being your least favorite.

Podiatry       Reproduction       Neonatal       Diagnostics/Imaging  
 Dentistry       Practice Management       Anesthesia       Sports Medicine

5455 Lexington Rd. • Lexington, KY 40511  
(p) 859.987.4303 • (f) 859.987.4304  
[officeparis@parkequinehospital.com](mailto:officeparis@parkequinehospital.com)



**RESIDENCY & CITIZENSHIP INFORMATION**

City and State (or country if not USA) of birth: \_\_\_\_\_  
(International Applicants will be required to apply for and obtain a J-1 Visa, at their own expense, to participate in the course)

**REFERENCES**

List three references who will be submitting a letter of recommendation on your behalf.

1. Name: \_\_\_\_\_ Relationship & Length: \_\_\_\_\_  
Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship & Length: \_\_\_\_\_  
Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship & Length: \_\_\_\_\_  
Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Email Address: \_\_\_\_\_  
\_\_\_\_\_

**ACADEMIC HISTORY**

List all Post-Secondary institutions you have attended **beginning with the most recent**.

<u>School Name</u>	<u>City/State</u>	<u>Major Dates Attended</u>	<u>Degree Awarded</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**AUTHORIZATION AND SIGNATURE**

I certify that all the information provided on and with this application is complete and accurate to the best of my knowledge. I understand that all information will be available to the Review & Selection Committee. I grant permission to Park Equine Hospital to verify any and all information pertinent to my application.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



Application packets may be mailed to:

Park Equine Hospital  
Attn: Admissions Committee  
5455 Lexington Road  
Lexington, KY 40511

OR Emailed in PDF format to Admissions Committee:

[applications@parkequinehospital.com](mailto:applications@parkequinehospital.com)

**5455 Lexington Rd. • Lexington, KY 40511**  
**(p) 859.987.4303 • (f) 859.987.4304**  
**[officeparis@parkequinehospital.com](mailto:officeparis@parkequinehospital.com)**