



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 has a flexible start date and will be for a period of one (1) year. Please fill in your requested start date: _____

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

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>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

AUTHORIZATION AND SIGNATURE

I certify that all the information provided on and within 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 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