



## INTERNSHIP APPLICATION

### SECTION I: PERSONAL INFORMATION

#### Personal Data (Please type or print clearly)

LAST NAME FIRST NAME

NAME AS IT APPEARS ON PASSPORT

ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE

E-MAIL FAX

DATE OF BIRTH AGE PASSPORT # EXP DATE

SEX:  MALE  FEMALE MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  WIDOWED

HOME CHURCH COUNTRY OF CITIZENSHIP

#### Education

COLLEGE / UNIVERSITY MAJOR/DEGREE EARNED YEAR OF GRADUATION

COLLEGE / UNIVERSITY MAJOR/DEGREE EARNED YEAR OF GRADUATION

Please describe any educational experiences that you believe have prepared you for this internship experience.

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## Skills and Talent

Please write the appropriate code next to the skills/talents you possess. CODES: 1-Average 2-Better than average 3-Professional. Please note that all of these areas may not be offered on all trips.

### CONSTRUCTION

\_\_\_\_\_ Carpentry  
\_\_\_\_\_ Painting  
\_\_\_\_\_ Masonry/Carpentry  
\_\_\_\_\_ Roofing  
\_\_\_\_\_ Electrical  
\_\_\_\_\_ Plumbing  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

### BUSINESS

\_\_\_\_\_ Computers  
\_\_\_\_\_ Accounting  
\_\_\_\_\_ Research  
\_\_\_\_\_ Project Management  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

### WEB

\_\_\_\_\_ Design/Graphics  
\_\_\_\_\_ Writing

### MINISTRY EXPERIENCE

\_\_\_\_\_ Teaching class: age \_\_\_\_\_  
\_\_\_\_\_ Children's ministries  
\_\_\_\_\_ Cross-cultural ministry  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

### MEDICAL

\_\_\_\_\_ Nursing  
\_\_\_\_\_ Physician  
\_\_\_\_\_ Dental  
\_\_\_\_\_ EMT  
\_\_\_\_\_ CPR  
\_\_\_\_\_ Therapy (PT; OT; other)  
\_\_\_\_\_ HIV/AIDS treatment  
\_\_\_\_\_ Home-based care  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

### MEDIA

\_\_\_\_\_ Photography  
\_\_\_\_\_ Journalism  
\_\_\_\_\_ Video

### MUSIC/PERFORMANCE

\_\_\_\_\_ Instrument (pls. list)  
\_\_\_\_\_  
\_\_\_\_\_ Vocal  
\_\_\_\_\_ Drama  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

### SOCIAL WORK

\_\_\_\_\_ Community Development  
\_\_\_\_\_ Counseling  
\_\_\_\_\_ Child Services  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

### COMPUTER SKILLS

\_\_\_\_\_ Microsoft Word  
\_\_\_\_\_ Microsoft Excel  
\_\_\_\_\_ Microsoft PowerPoint  
\_\_\_\_\_ Other (pls. specify)  
\_\_\_\_\_

## Languages Spoken (include last level taken and proficiency, i.e. fluent, fair, poor):

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## International Travel Experiences:

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On a separate sheet, please submit an essay of 1,000 words or less explaining why you are interested in the internship program at Bright Hope International.

**SECTION II: CONFIDENTIAL INFORMATION FOR USE IN MEDICAL EMERGENCIES**

FULL NAME

BLOOD TYPE

SOCIAL SECURITY NUMBER

NAME OF YOUR PHYSICIAN

ADDRESS

CITY

STATE

ZIP

OFFICE PHONE

HOME PHONE

Please list all the drugs/medications you are presently taking indicating the generic name, exact strengths, and dosage: \_\_\_\_\_

List medical problems for which you have received medical care in the past 12 months: \_\_\_\_\_

List any history of major illness or surgery: \_\_\_\_\_

Date of most recent tetanus immunization: \_\_\_\_\_

List any known allergies (including food allergies) or chronic life-threatening conditions: \_\_\_\_\_

Please list any medical conditions helpful for a physician to know should you require emergency medical attention during the trip: \_\_\_\_\_

Describe your present physical fitness (e.g., walking, manual labor, heavy lifting, carrying luggage): \_\_\_\_\_

**Emergency Authorization**

I give any licensed, practicing physician or hospital full authority to provide emergency medical treatment for me in the event such treatment is needed or necessary and I am not able to make such a decision. I also hereby give my permission for a licensed practicing physician to administer whatever medical treatment he/she may deem necessary for me in the event of any medical emergency affecting me.

SIGNATURE

DATE

**In Case of Emergency Contact**

NAME:

E-MAIL ADDRESS

ADDRESS

CITY

STATE

ZIP

RELATIONSHIP TO APPLICANT

HOME PHONE

WORK PHONE

CELL PHONE:

**PROGRAM REFERENCE: EMPLOYER OR INSTRUCTOR**

To be completed by a recent employer or current college instructor who has known you for at least six months (cannot be a family member).

NAME OF APPLICANT TO BRIGHT HOPE INTERNSHIP PROGRAM

HOW LONG HAVE YOU KNOWN THE APPLICANT?

IN WHAT CAPACITY?

General Comments:

Please evaluate the applicant as to:

|                                     |                                    |                               |                               |                               |
|-------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Ability to accept supervision:      | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |
| Ability to get along with others:   | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |
| Ability to adapt to new situations: | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |
| Ability to relate cross-culturally: | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |

Please explain as necessary:

Referree's Details:

NAME

TITLE

COMPANY / INSTITUTION

ADDRESS

CITY

STATE

ZIP

OFFICE PHONE

EMAIL

SIGNATURE

DATE

**Please return to:** Bright Hope  
Attn: Intern Coordinator  
2060 Stonington Ave.  
Hoffman Estates, IL 60169

**PROGRAM REFERENCE: COUNSELOR OR PASTOR**

To be completed by a counselor or pastor who has known you for at least six months (cannot be a family member).

NAME OF APPLICANT TO BRIGHT HOPE INTERNSHIP PROGRAM

HOW LONG HAVE YOU KNOWN THE APPLICANT?

IN WHAT CAPACITY?

General Comments:

Please evaluate the applicant as to:

|                                     |                                    |                               |                               |                               |
|-------------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Ability to accept supervision:      | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |
| Ability to get along with others:   | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |
| Ability to adapt to new situations: | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |
| Ability to relate cross-culturally: | excellent <input type="checkbox"/> | good <input type="checkbox"/> | fair <input type="checkbox"/> | poor <input type="checkbox"/> |

Please explain as necessary:

Referree's Details:

NAME

TITLE

COMPANY / INSTITUTION

ADDRESS

CITY

STATE

ZIP

OFFICE PHONE

EMAIL

SIGNATURE

DATE

**Please return to:** Bright Hope  
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2060 Stonington Ave • Hoffman Estates, IL 60169 • Phone: 224-520-6100 • Fax: 847-519-0024

### AGREEMENT AND RELEASE OF LIABILITY

ACTIVITY: \_\_\_\_\_

DATE AND LOCATION OF ACTIVITY: \_\_\_\_\_

CONTACT PERSON: \_\_\_\_\_ PHONE: \_\_\_\_\_

I (print name) \_\_\_\_\_ wish to participate on a mission trip to a foreign country. I acknowledge and understand that participation in this internship is entirely voluntary and that my participation includes many risks and possible dangers such as accidents, disease, war, political unrest, irregularity in schedule, injury from construction projects and other calamities.

I declare that I am physically fit and capable of taking part in such activity. I make this declaration on the basis of advice given me by my duly licensed medical doctor within the last 12 months, and I know of no change in my medical condition since receiving such advice which would affect the opinion of such doctor.

In signing this form, I warrant and represent that I am eighteen years of age or older. I agree that in consideration of Bright Hope International sponsoring this activity and permitting me to participate, I will indemnify, defend, and hold harmless, release and discharge Bright Hope International, its constituent organizations, and its officers, agents and employees from any and all claims for personal injuries, property damage or wrongful death that I may suffer as a result of my participation in the activity described above, whether or not such injuries or damages are caused by the negligence (active or passive) of any of the entities or individuals named or described above.

I agree to abide by the rules and regulations governing the above-described activity and to obey any instructions given by the person or persons having supervision and control over the activity.

I hereby authorize the making of photographs, motion pictures, videotapes, recordings or other memorializations of said event and my participation therein, and the publication or other use thereof. I hereby waive any right to compensation therefor or any right that I otherwise might have to limit or control such.

I have read and understand the above provisions and agree to be bound by them as indicated by my signature below.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
ADDRESS

\_\_\_\_\_  
TELEPHONE NUMBERS: HOME

\_\_\_\_\_  
CELL

PERSON TO CONTACT IN CASE OF EMERGENCY:

\_\_\_\_\_  
NAME

\_\_\_\_\_  
PHONE