**Child Life and Family Education**
**Practicum Student Application**

Application for Practicum Session: _____

## CONTACT INFORMATION

Full Name:  _____

Address:  _____
   *Street Address*                                                                 *Apartment/Unit#*

   _____
   *City*                                                  *State*                                 *ZIP Code*

Phone:  _____

E-mail Address:  _____

## EDUCATION

Academic Institution:  _____

Major:  _____     G.P.A.:  _____     Expected Graduation Date:  _____

Advisor's Name:  _____

Advisor's Phone:  _____     E-mail Address:  _____

*List courses taken which are relevant to child life practice (include date and grade for each):*

|  |  |
|---|---|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

## EXPERIENCE

*List child related experiences that have prepared you for this practicum:*

| Dates | Role/Responsibilities | Site Name | Number of Hours |
|---|---|---|---|
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please answer the following questions separately and attach to the application:

1. How did you become aware of and interested in Child Life?
2. Describe your philosophy in regards to Child Life and an experience that helped you developed this perspective.
3. What to do you hope to gain if accepted into this practicum program?

## REFERENCES

Please include two letters of recommendation (professional and/or academic) with this application. Letters should be sealed in envelopes. Please list below the names of the individuals writing the letters.

1. Name: _____    Title: _____

2. Name: _____    Title: _____

## CHECKLIST

To complete your application, please submit the following in order to be considered for the practicum:

☐ Current resume

☐ 1 page answer: Why have you decided to apply to Comer Children's Hospital for this practicum opportunity?

☐ Answers to application questions

☐ Unofficial academic transcripts for undergraduate and graduate school (minimum G.P.A. of 3.0 for current degree)

☐ 2 Letters of recommendation (one from an academic source)

I certify that the responses on this document are true to the best of my knowledge. I understand it is the sole responsibility of the applicant to confirm receipt of the application packet. I understand if my application packet is incomplete, I *will not* be considered for the practicum program.

Signature: _____    Date: _____

**Application deadlines (postmarked by):**

- Winter/Spring: October 1st
- Summer: March 1st
- Fall: June 1st

**Return the completed application and required documents to:**

The University of Chicago Medicine Comer Children's Hospital
Child Life and Family Education, MC 8008
Attn: Amy Carter / Practicum Coordinator
5721 S. Maryland Avenue, Room K-135
Chicago, IL 60637-1470

For further information, please contact Amy Carter at 773-702-0407 or amy.carter@uchospitals.edu.