Project | SEARCH

New Intern Application

Name _____

Please select a classroom location(s):

☐ **Bryn Mawr Rehab Hospital | Malvern, PA**

☐ **Lankenau Medical Center | Wynnewood, PA**

☐ **I am interested in both locations**

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

The purpose of this application packet is to outline the skill set of the Project SEARCH intern. This application enables the Selection Committee* to properly assess each intern's skills, abilities and background. You may be contacted by the Selection Committee to gather additional information. Our final goal is to select interns who will be successful in a Project SEARCH program and reach the outcome of competitive employment.

The Selection Process includes the following guidelines:

1. Submit the completed application to:

   Project SEARCH
   Bryn Mawr Rehab Hospital
   414 Paoli Pike
   Malvern, PA 19355

2. The Selection Committee will review the applications, and if accepted, match the intern skill set and interests with the appropriate Project SEARCH Program.

3. If accepted, the intern must be able to pass a criminal background check, child abuse check, drug screen and receive a flu shot prior to the flu season.

Please note:
* The Selection Committee will include a Project SEARCH Coordinator, representatives from the host business and a PA Office of Vocational Rehabilitation Counselor.

Application for Internship

Project | SEARCH

PLEASE NOTE
ALL THE REQUIRED DOCUMENTS MUST BE COMPLETED AND SUBMITTED TOGETHER FOR CONSIDERATION

☐ **Completed Application Packet**

☐ **Resume**

☐ **Signed Consent for Use of Protected Health Information**

☐ **Completed Consent for a Background Check and Child Abuse Clearance**

Return completed packet to:

Project SEARCH
Bryn Mawr Rehab Hospital
414 Paoli Pike
Malvern, PA 19335
484-596-5406 (Phone)
484-596-3940 (Fax)

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

Please complete and return to Bryn Mawr Rehab Hospital Project SEARCH Program

Personal Data

Name _____
Last First Middle

Address: _____
Street City Zip Code

County of Residence: _____

Date of Birth: _____ ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____

Email Address: _____

Diagnosis/Disability: _____

Onset of Diagnosis/Disability: _____

How did you learn about Project SEARCH? _____

_____

FUTURE EMPLOYMENT PREFERENCES and BACKGROUND:

How do you want to be employed in the community upon completion of Project SEARCH?

☐ Full time (36-40 hours per week) ☐ Part time (16-35 hours per week)

Which shift would you prefer working after completing Project SEARCH?

☐ 1st Shift (7am – 3pm) ☐ 2nd Shift (3pm- 11pm) ☐ 3rd Shift (11pm- 7am)

Would you be willing to work holidays and/or weekends?

☐ Yes ☐ No

What would you be interested in doing for an internship?

For examples of internship opportunities, please visit our webpage www.mainlinehealth.org/projectsearch and select FAQ

_____

_____

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

COMPUTER SKILL SET: Select the level of computer application knowledge that applies:

Program	Never Used	Beginner	Intermediate	Advanced
Word				
Excel				
PowerPoint				
Outlook Email				
Publisher				
Internet				
Other:				

EMPLOYABILITY SKILLS: Select the level that applies:

Skill	Never	Sometimes	Frequently
Is on time for scheduled events (punctuality)			
Is motivated			
Is easily distracted			
Tires easily			
Receptive to feedback			
Is aware of cultural, gender and generational differences.			
Is aware of professional boundaries			
Demonstrates initiation			
Asks for help when needed			
Is responsible			
Able to problem solve independently			
Uses strategies			

BUSINESS MACHINE OPERATION: Select the level of machine operation that applies:

Name	Never	Sometimes	Frequently
Laptop Computer			
Desktop Computer			
Scanning Machine			
Printer			
Copier			
Fax Machine			
Telephone (Transferring calls; putting people on hold; overhead paging; etc.)			
Cash Register			

Application for Internship

Project | SEARCH

List jobs and/or volunteering you do or have done (starting with most recent):
Please use a separate piece of paper if needed.

1. Employer: _____ **Start Date:** _____ **End Date:** _____

Job Title: _____ **Paid:** ☐ **Unpaid/Volunteer:** ☐

Job Responsibilities: _____

_____

Supervisor Name and Contact Number: _____

Reason for leaving: _____

2. Employer: _____ **Start Date:** _____ **End Date:** _____

Job Title: _____ **Paid:** ☐ **Unpaid/Volunteer:** ☐

Job Responsibilities: _____

_____

Supervisor Name and Contact Number: _____

Reason for leaving: _____

3. Employer: _____ **Start Date:** _____ **End Date:** _____

Job Title: _____ **Paid:** ☐ **Unpaid/Volunteer:** ☐

Job Responsibilities: _____

_____

Supervisor Name and Contact Number: _____

Reason for leaving: _____

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

Have you ever been fired from a job?
☐ Yes ☐ No

If yes, please explain:

Have you ever quit a job?
☐ Yes ☐ No

If yes, please explain:

Have you even been charged with a felony? As part of the application process Project SEARCH will complete a background check on all applicants. If you do not fully disclose on this application, it may impact your acceptance into the program.
☐ Yes ☐ No

If yes, please explain:

Have you even been charged with a misdemeanor? As part of the application process Project SEARCH will complete a background check on all applicants. If you do not fully disclose on this application, it may impact your acceptance into the program.
☐ Yes ☐ No

If yes, please explain:

SERVICE AGENCIES:

Do you have a Vocational Rehabilitation Counselor?
Yes ☐ Name _____ Phone Number: _____
No ☐
If No, have you applied: Yes ☐ No ☐ Date Applied: _____

Are you eligible for services from the County?
Yes ☐ Name _____ Phone Number: _____
No ☐

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

INDEPENDENT LIVING:

Medications/ Dosage/ Time of day taken by intern

Medication	Dosage	Time of day

List any health or medical issues that may impact a successful job placement

_____

_____

_____

Please list any limitations that impact employment:

_____

_____

_____

_____

What is your primary means of transportation? (Example: Independent driver, family/friends, Rover, Septa, etc.)

_____

_____

BEHAVIORAL SUMMARY:

Do you have any behaviors that need to be supported in order to have a successful job placement?

☐ Yes ☐ No

Please Explain:

_____

_____

_____

_____

_____

_____

Bryn Mawr Rehab Hospital

Main Line Health

Application for Internship

Project | SEARCH

INTERN RESPONSE QUESTION

Why do you want to be part of Project SEARCH? (Complete in your own words write your response below)

List Three References:

	Name	***Type of Reference***	***Phone Number***	***Email Address***
1.		Family Reference		
2.		Professional Reference		
3.		Other Community or Agency Reference		

The person assisting the intern to complete this application is:

Name	Title	Phone Number	Date
Organization	Phone Number	Email contact	

Applicant/Intern Signature

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

Consent for Use of Protected Health Information

I give my consent to the **Main Line Health System** and all health care providers furnishing care within the Hospital's facilities to use and disclose my protected health information for my treatment, for payment and for hospital operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose information about you. You have the right to review our Notice before you sign this consent.

We can change the terms of our Notice. Our current Notice can be found on our web site: http://www.mainlinehealth.org or from any of our patient access areas.

You can request we restrict how we use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. We will accommodate your request if we can, but we are not obligated to do so.

We may use your health information to send you additional information about services or programs related to your health care. If you object to receiving this type of information from us, initial here _____.

You may revoke your consent at any time. Your revocation must be in writing, signed by you or by your personal representative on your behalf. Your revocation will be effective when we receive it. Your revocation will not be effective to the extent that we or others acted in reliance on your original consent.

_____
Signature of Applicant/Intern

_____
Name of Applicant/Intern – Print

_____
Date

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

Consent for Use of Protected Health Information

I give my consent to the **Pennsylvania Office of Vocational Rehab (OVR)** to use and disclose my protected health information for my treatment, for payment and for program operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose information about you. You have the right to review our Notice before you sign this consent.

We can change the terms of our Notice. Our current Notice can be found on our web site: http://www.mainlinehealth.org or from any of our patient access areas.

You can request we restrict how we use and disclose your protected health information for the purpose of treatment, payment and healthcare operations. We will accommodate your request if we can, but we are not obligated to do so.

You may revoke your consent at any time. Your revocation must be in writing, signed by you or by your personal representative on your behalf. Your revocation will be effective when we receive it. Your revocation will not be effective to the extent that we or others acted in reliance on your original consent.

_____
Signature of Applicant/Intern

_____
Name of Applicant/Intern – Print

_____
Date

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

BACKGROUND CHECK DISCLOSURE AND AUTHORIZATION FORM
[FOR PROGRAM PURPOSES]

In connection with your employment or application for employment, please be advised that we may obtain a *consumer report* and/or an *investigative consumer report* including information as to your creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. You have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the investigation requested. In the event that information from the report is utilized in whole or in part in making an adverse decision, before making the adverse decision, we will provide to you a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act,15 U.S.C. § 1681 et seq.

Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. § 1681 *et seq*., is available at the Federal Trade Commission's web site (www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552. http://www.ftc.gov). For more information, including information about additional rights, go to

Consent to Obtain Consumer Reports

By signing below, I authorize the company to obtain one or more consumer reports regarding my creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics, and mode of living. I hereby authorize all entities having information about me, including present and former employers, personal references, criminal justice agencies, departments of motor vehicles, schools, licensing agencies, and credit reporting agencies, to release such information to the company or any of its affiliates or carriers.] I acknowledge and agree that this Background Check Disclosure and Authorization Form shall remain valid and in effect during the term of my employment.

Date:_____

Signature of Applicant/Intern: _____

Print Name: _____

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

INFORMATION FOR PROCESSING OF BACKGROUND SCREEN REPORTS ONLY
(to be used for no other purposes)
Please write legibly:

Full Name: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Primary Phone Number: _____ Email Address:_____

Drivers License Number: _____ State of Issue: _____

Current Address: _____
(Number and Street, Apt # if applicable)

_____ _____ _____
City State Zip Code

List all Residence Addresses in Past Seven Years (attach additional sheets if necessary)

_____

_____

_____

_____

_____

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

CONSENT/RELEASE OF INFORMATION AUTHORIZATION FORM FOR THE PENNSYLVANIA CHILD ABUSE HISTORY CLEARANCE

I,_____ (Applicant's Name), hereby authorize the PA Department of Human Services, ChildLine to release my Pennsylvania Child Abuse History Clearance information directly to Main Line Health - HR.

I understand that this information is confidential in nature pursuant to §6340 (relating to information in confidential reports) of the Child Protective Services Law (CPSL) (23 Pa.C.S Chapter 63) and will not otherwise be released by the Main Line Health - HR without my express authorization or pursuant to authorization by Title 55 of the Pennsylvania Code. **I also understand that the aforementioned information will not be released directly to me _____ (Applicant's Name) as stated in the Pennsylvania Child Abuse History Clearance application.**

I understand that I will not receive a copy of my Pennsylvania Child Abuse History Clearance directly from ChildLine; however, I may request a copy of my Pennsylvania Child Abuse History Clearance from Main Line Health - HR upon written request.

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

I have read this Consent/Release of Information Authorization form and fully understand and agree to its content. I further understand and agree to all information and ramifications of the Pennsylvania Child Abuse History Clearance application as it otherwise relates to this consent. Further I understand that if I am listed in the statewide central registry for child abuse that my consent allows the result stating such information to be shared with the agency/organization noted.

Please send my clearances result(s) to: Melany Cordova

Agency Name: **Main Line Health – HR Dept**

Agency Street Address: **240 North Radnor Chester Rd**

Agency City, State, Zip Code: **Radnor, PA 19087**

_____ _____

Date Applicant's Signature

As the agency/organization representative, I understand that, except for the subject of a report, persons who receive this information are subject to the confidentiality provisions of the CPSL and 55 Pa. Code, Chapter 3490 and are required to ensure the confidentiality and security of the information and are liable for civil and criminal penalties for releasing information to persons who are not permitted access to this information. I agree to receive and maintain this information in accordance with these requirements.

_____ _____

Date Agency Representative's Signature

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION

Type or print clearly in ink. If obtaining this certification for non-volunteer purposes or if, as a volunteer having contact with children, you have obtained a certification free of charge within the previous 57 months, enclose an $8.00 money order or check payable to the PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES or a payment authorization code provided by your organization. **DO NOT send cash.**

Certifications for the purpose of "volunteer having contact with children" may be obtained free of charge once every 57 months.

Send to CHILDLINE AND ABUSE REGISTRY, PA DEPARTMENT OF HUMAN SERVICES, P.O. BOX 8170 HARRISBURG, PA 17105-8170.

APPLICATIONS THAT ARE INCOMPLETE, ILLEGIBLE OR RECEIVED WITHOUT THE CORRECT FEE WILL BE RETURNED UNPROCESSED. IF YOU HAVE QUESTIONS CALL 717-783-6211, OR (TOLL FREE) 1-877-371-5422.

PURPOSE OF CERTIFICATION (Check one box only)

- ☐ Foster parent
- ☐ Prospective adoptive parent
- ☐ Employee of child care services
- ☐ School employee governed by the Public School Code
- ☐ School employee not governed by the Public School Code
- ☐ Self-employed provider of child-care services in a family child-care home
- ☐ An individual 14 years of age or older applying for or holding a paid position as an employee
- ☑ An individual seeking to provide child-care services under contract with a child care facility or program
- ☐ An individual 18 years or older who resides in the home of a foster parent, licensed child-care home, family living home, community home for individuals with an intellectual disability, or host home for children for at least 30 days in a calendar year
- ☐ An individual 18 years or older who resides in the home of a prospective adoptive parent for at least 30 days in a calendar year

- ☐ Volunteer having contact with children

If purpose is volunteer having contact with children, choose SUB PURPOSE:

- ☐ Big Brother/Big Sister and/or affiliate
- ☐ Domestic violence shelter and/or affiliate
- ☐ Rape crisis center and/or affiliate
- Other: _____

☐ PA Department of Human Services Employment & Training Program participant (signature required below)

_____ SIGNATURE OF OIM/CAO REPRESENTATIVE

_____ OIM/CAO PHONE NUMBER

AGENCY/ORGANIZATION NAME:
Main Line Health HR

PAYMENT AUTHORIZATION CODE, IF APPLICABLE:

☑ Consent/Release of Information Authorization form is attached. Applicant must fill in the "Other Address" sections. By completing the other address sections, you are agreeing that the organization will have access to the status and outcome of your certification application.

APPLICANT DEMOGRAPHIC INFORMATION (DO NOT USE INITIALS)

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

SOCIAL SECURITY NUMBER	GENDER	DATE OF BIRTH (MM/DD/YYYY)	AGE
___ ___	☐ Male ☐ Female ☐ Not reported		

Disclosure of your Social Security number is voluntary. It is sought under 23 Pa.C.S. §§ 6336(a)(1) (relating to information in statewide database), 6344 (relat- ing to employees having contact with children; adoptive and foster parents), 6344.1 (relating to information relating to certified or licensed child-care home residents), and 6344.2 (relating to volunteers having contact with children). The department will use your Social Security number to search the statewide database to determine whether you are listed as the perpetrator in an indicated or founded report of child abuse.

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

HOME ADDRESS	MAILING ADDRESS (if different from home address)	OTHER ADDRESS (if Consent/Release of Information Authorization form is attached)
ADDRESS LINE 1	ADDRESS LINE 1	ADDRESS LINE 1 240 North Radnor Chester Road
ADDRESS LINE 2	ADDRESS LINE 2	ADDRESS LINE 2
CITY	CITY	CITY Radnor
COUNTY	COUNTY	COUNTY Delaware County
STATE/REGION/PROVINCE	STATE/REGION/PROVINCE	STATE/REGION/PROVINCE Pa
ZIP/POSTAL CODE	ZIP/POSTAL CODE	ZIP/POSTAL CODE 19087
COUNTRY	COUNTRY	COUNTRY United States
Different mailing address	ATTENTION	ATTENTION Melany Cordova

CONTACT INFORMATION		
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	MOBILE TELEPHONE NUMBER
EMAIL (By submitting an email contact, you are agreeing to ChildLine contacting you at this address.)		

PREVIOUS NAMES USED SINCE 1975 (Include maiden name, nickname and aliases.)			
First	Middle	Last	Suffix
1.			
2.			
3.			
4.			
5.			

PREVIOUS ADDRESSES SINCE 1975 (Please list all addresses since 1975, partial address acceptable; attach additional pages if necessary.)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

HOUSEHOLD MEMBERS (Please list everyone who lived with you at any time since 1975 to present. Please include parent, guardian or the person(s) who raised you; attach additional pages as necessary.)			
Name (First, Middle, Last)	**Relationship**	**Present Age**	**Gender**
1.	☐ Parent ☐ Guardian ☐ person(s) who raised you		
2.	☐ Parent ☐ Guardian ☐ person(s) who raised you		
3.			
4.			
5.			
6.			
7.			
Name (First, Middle, Last)	**Relationship**	**Present Age**	**Gender**
8.			
9.			
10.			

I affirm that the above information is accurate and complete to the best of my knowledge and belief and submitted as true and correct under penalty of law (Section 4904 of the Pennsylvania Crimes Code). If I selected volunteer, I understand that I can only use the certificate for volunteer purposes.

APPLICANT'S SIGNATURE

DATE

CHILDLINE USE ONLY		
DATE RECEIVED BY CHILDLINE	SUFFICIENT PAYMENT INFORMATION RECEIVED ☐ YES ☐ NO ☐ VALID PAYMENT AUTHORIZATION CODE ☐ WAIVED (supervisor initials) _____	CERTIFICATION ID #

Bryn Mawr Rehab Hospital
Main Line Health

Application for Internship

Project | SEARCH

INSTRUCTIONS TO COMPLETE THE PENNSYLVANIA CHILD ABUSE HISTORY CERTIFICATION APPLICATION:

General:

- Type or print clearly and neatly in ink only.
- If obtaining this certification for non-volunteer purposes or if, as a volunteer having contact with children, you have obtained a certification free of charge within the previous 57 months, enclose an $8.00 money order or check for each application. No cash will be accepted. Personal, agency, or business checks are acceptable. Certifications for the purpose of "volunteer having contact with children" may be obtained free of charge once every 57 months. If no payment is enclosed for a non-volunteer purpose, you must provide a payment authorization code, otherwise your application will be rejected and returned to you.
- **DO NOT SEND POSTAGE PAID RETURN ENVELOPES** for us to return your results. Results are issued through an automated system generated mailing process.
- Certification results will be mailed to you within 14 days from the date the certification application is received at the ChildLine and Abuse Registry.
- Failure to comply with the instructions will cause considerable delay in processing the results of an applicant's child abuse history certification application.

Purpose of Certification - Do not check more than one box:

- Check the **foster parent** box if applying for purposes of providing foster care.
- Check the **prospective adoptive parent** box if applying for the purpose of adoption.
- Check the **employee of child care services** box if applying for the purpose of child care services in the following:
  - Child day care centers; group day care homes; family day care homes; boarding homes for children; juvenile detention center services or programs for delinquent or dependent children; mental health services for children; services for children with intellectual disabilities; early intervention services for children; drug and alcohol services for children; and day care services or other programs that are offered by a school.
- Check the **school employee governed by the Public School Code** box if you are a school employee who is required to obtain background checks pursuant to Section 111 of the Public School Code and will continue to be required to obtain background checks prior to employment in accordance with that section and on the periodic basis required by Act 153.
- Check the **school employee not governed by the Public School Code** box if you are a school employee not governed by Section 111 of the Public School Code, but covered by Act 153 (pertaining to school employees in institutions of higher education).

  Definition of school employee: A school employee is defined as an individual who is employed by a school or who provides a program, activity or service sponsored by a school. The term does not apply to administrative or other support personnel unless they have direct contact with children.

  Definition of school: A facility providing elementary, secondary or postsecondary educational services. The term includes the following:

  (1) Any school of a school district.
  (2) An area vocational-technical school.
  (3) A joint school.
  (4) An intermediate unit.
  (5) A charter school or regional charter school.
  (6) A cyber charter school.
  (7) A private school licensed under the act of January 28, 1988 (P.L.24, No. 11), known as the Private Academic Schools Act.
  (8) A private school accredited by an accrediting association approved by the state Board of Education.

Project | SEARCH

(9) A non-public school.
(10) An institution of higher education.
(11) A private school licensed under the act of December 15, 1986 (P.L. 1585, No. 174), known as the Private Licensed Schools Act.
(12) The Hiram G. Andrews Center.
(13) A private residential rehabilitative institution as defined in section 914.1A(c) of the Public School Code of 1949.

- Check the **self-employed provider of child-care services in a family child-care home** if providing child care services in one's home (other than the child's own home) at any one time to four, five, or six children who are not relatives of the caregiver.
- Check the **individual 14 years of age or older who is applying for or holding a paid position as an employee** box if the employment is with a program, activity, or service, as a person responsible for the child's welfare or having direct contact with children.
- Check the **individual seeking to provide child care services under contract with a child care facility or program** box if you are providing child care services as part of a contract or grant funded program.
- Check the box for **individual 18 years or older who resides in the home of a foster parent, licensed child-care home, family living home, community home for individuals with an intellectual disability or host home for children for at least 30 days in a calendar year** if you are an adult household member, excluding an individual with an intellectual disability or chronic psychiatric disability receiving services, in one of these types of settings and require certification.
- Check the box **for individual 18 years or older who resides in the home of a prospective adoptive parent for at least 30 days in a calendar year** if you are an adult household member in this setting and require certification.
- Check the **volunteer having contact with children** box if applying for the purpose of volunteering as an adult for an unpaid position as a volunteer with a child-care service, a school, or a program, activity or service as a person responsible for the child's welfare or having direct volunteer contact with children. In addition, check the box of one of the organizations listed, i.e. Big Brother/Big Sister, domestic violence shelter, rape crisis center. If you are **NOT** applying for a volunteer in one of the organizations listed, please check the **other** box and write the name of the organization in the space provided.
- Check the **PA Department of Human Services employment & training program participant** box if you are applying for the purpose of participating in a PA Department of Human Services employment and training program through a county assistance office (CAO) or the Office of Income Maintenance (OIM). The signature AND phone number of the CAO or OIM representative is required. If there is no signature and no phone number, your application will be rejected and returned to you.
- If you were provided a **"PAYMENT AUTHORIZATION CODE"** by an organization, please provide the **agency/organization name** in the space provided and the payment authorization code in the space provided.
- Please check the **CONSENT/RELEASE OF INFORMATION** box if you included a payment code in the space above and attached the completed Consent/Release of Information Authorization form to your Pennsylvania Child Abuse History Certification application when you mail it to our office. The Consent/Release of Information Authorization form allows the department to send your results to a third party. If the Consent/Release of Information Authorization form is **NOT** attached to the certification application, the results **WILL** be mailed to the applicant's home address and not to the third party.

Applicant Demographic Information:

- Name - Include the applicant's full legal name. Initials are not acceptable for a first name. If your full legal name is an initial, please provide supporting documentation along with your certification application.
- Social Security number - Include the applicant's social security number. A social security number is voluntary; **HOWEVER, PLEASE NOTE THAT APPLICATIONS THAT DO NOT INCLUDE SOCIAL SECURITY NUMBERS MAY TAKE LONGER TO BE PROCESSED.**
- Gender - Please check one box.
- Date of birth - Fill in the applicant's date of birth (Example: 01/22/1990).
- Age - Fill in the applicant's current age.

Address:

- The address listed must be the applicant's current home address. This is also where the results of the certification will be mailed, unless otherwise noted. If the **different mailing address** box is checked and a mailing address is provided in the "different" mailing address column, the results will be mailed to the "mailing" address and not the "home" address. **Note**: If the consent/release of information box is checked and an "other" address is provided, the results will be mailed to the "other" address.

Application for Internship

Project | SEARCH

Contact Information:

- Please provide your home, work or mobile telephone number. Fill in the number where the applicant can be reached in the event that there are questions about the information on the application.
- Please provide an email address. By providing an email address, you are consenting to ChildLine contacting you by email in the event that you cannot be reached by phone. **NO CONFIDENTIAL INFORMATION WILL EVER BE SHARED OR PROVIDED IN AN EMAIL FROM OUR OFFICE.**

Previous Names Used Since 1975:

- The applicant must list any and all full legal names that they have ever had since 1975. This includes maiden names, nicknames, aliases and also known as (aka) names.

Previous Addresses Since 1975:

- List all addresses where the applicant has resided since 1975. The applicant can attach an additional sheet of paper with all of the addresses listed if necessary. If the applicant cannot remember the exact mailing addresses since 1975, filling in as much information as possible about the location is acceptable.

Household Members:

- Include anyone that the applicant lived with since 1975 (parents, guardians, siblings, children, spouse (ex), paramour, friends, etc.). In addition, include the household member's relationship to the applicant, their age (to the best of your knowledge) and their gender. If the applicant was under the age of 18 in 1975, this section **MUST** include the applicant's PARENT(S) or GUARDIAN(S). If this section is left blank, the application will be rejected and returned to the applicant.

Signature:

- Applications MUST be signed and dated. Applications that are not signed and dated will be rejected and returned to the applicant.

CHILDLINE USE ONLY:

- Please DO NOT WRITE in this section. This is for CHILDINE staff only.

Additional Information:

Applicants can visit https://www.compass.state.pa.us/CWIS for more information about submitting the child abuse certification online or to register for a business/organization account.

Application for Internship

Project | SEARCH

Intern Contract

Read the Intern Contract below and sign and date.

I, _____, understand that I have been accepted into the Project SEARCH program and must abide by the following terms and conditions:

- I will complete at least three unpaid job rotations within the host business.
- I will attend the program every day, Monday through Friday.
- I will dress appropriately and wear required attire.
- I will call my instructor and departmental supervisors when I am absent or tardy.
- I will make up any time missed due to excused absences.
- I understand that I am responsible for transportation to the host site.
- I will learn to use public transportation when available.
- I will follow all the rules established by the program and host business.
- I will attend monthly meetings with my rehabilitation counselor and business staff.
- I will be an active participant and communicate any issues at our monthly meetings.
- At completion of the program, I will actively pursue employment.

I have read the above terms and conditions and agree to accept my placement in the Project SEARCH program. I understand that I may be asked to leave Project SEARCH if I fail to follow the terms and conditions.

_____ _____

Intern Signature Date

The intern will be asked to sign this upon acceptance into the program.

Bryn Mawr Rehab Hospital
Main Line Health