



Child Life Practicum Application

Winter session 20____ Spring session 20____ Fall session 20____

Type or print legibly in black ink.

Name	E-mail address
Address	
Telephone number	Social Security number
Date of birth	Overall GPA
University	
Address	
University advisor	
Telephone number	E-mail address
Major	Anticipated date of graduation
Minor	

In case of emergency, contact information

In the event of illness or injury, which I may incur during this learning experience, I hereby instruct Marshfield Clinic Health System and its agents to secure appropriate medical care and to notify the individual listed below:

Name _____ Relationship _____

Address _____

Telephone number _____

I wholly and expressly release Marshfield Clinic Health System from any and all liabilities now and in the future associated with my actions during this experience.

Applicant's signature _____ Date (m/d/y) ____ / ____ / ____

Attach a response to the following questions.

When did you first hear of child life?

What are your areas of interest (i.e. patient populations and why)?

How do you visualize child life spending their time in the hospital or clinic setting?

What do you believe are the benefits of a child life practicum experience?

What three succinct goals do you wish to accomplish during a practicum experience?

Application will be complete upon receipt of all of the following materials:

- **Completed application**
- **Copy of transcripts – student copy OK**
- **Resume**
- **One letter of recommendation**

Email completed application to:

childlife@marshfieldclinic.org

Or mail completed application to:

Heidi Giese, B.S., CTRS, CCLS, CIMI

Manager, Child Life and Expressive Therapies Department

Marshfield Children's Hospital

611 St. Joseph Avenue

Marshfield, WI 54449

Phone 715-387-7361

After reviewing applications, I will contact you to set-up an interview.

Upon acceptance, all required health work must be completed at least 6 weeks prior to start date in order for you to start the practicum.