Marshfield Clinic
Health System

Master in Social Work Externship Application

Instructions: Complete this application form by answering all the questions and return via email. Mail your curriculum vita and a statement that includes your reasons for seeking this externship, your career goals, and what attributes you bring to this externship. Request three letters of recommendation (with particular reference to your clinical skills) be sent via email and regular mail. Have your transcripts sent via regular mail. Depending on the site you choose (if you want to be considered for more than one site, insure the information is sent to all sites of interest), send the information to:

Marshfield Clinic Health System

Wendy Chryst, LCSW
APSW Training Director

Marshfield Behavioral Health
Russell Lewis Building
1000 N. Oak Ave.
Marshfield WI, 54449

715-384-5728
715-389-3040 (fax)
chryst.wendy@marshfieldclinic.org

With my submission of this application, I give permission for the Marshfield Clinic Health System to contact my graduate program, internship and references: ☐ *Yes* ☐ *No (a* ***No*** *will prevent application review/consideration)*

General Information

Name (last, first, middle)		
Home address		
Work address		
Home phone	Cell phone	Work phone
Email		

Graduate School Information

Institution name		
City, state		
Dates attended	Type of program (degree, specialty)	Date degree received/expected

Name and email address of Director of Master in Social Work Training _____

_____

Was your Master in Social Work Program accredited by the Council on Social Work Education (CSWE):
☐ Yes ☐ No

What was the MSW program track you completed _____

_____

Undergraduate School Information

Institution name	
City, state	
Dates attended	Type of degree and major

Internship Information

Institution name	
City, state	
Dates attended	Type of program

Name and email address of Director of Internship Training _____

_____

Name and email address of Primary Clinical Supervisor _____

_____

Relevant Employment

Current position _____

Settings _____

Dates _____

Clinical activities _____

_____

Name and email address of supervisor _____

_____

Hours on-site _____

Previous positions _____

1. _____

2. _____

Have any formal complaints been filed against you with a licensing or ethics board: ☐ Yes ☐ No

Have you at any time been excluded from participation in a federally funded program, including Medicare and Medicaid: ☐ Yes ☐ No

