Madison
REGIONAL HEALTH SYSTEM
323 SW 10th St. | Madison, SD 57042
Phone: 605-256-6551 Fax:605-256-6469
www.madisonregionalhealth.org

Application for Madison Regional Health System Internship Programs

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Your Information

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Academic Institution: _____

Major: _____ Minor: _____

Date of Birth: _____

Emergency Contact Name: _____ Phone: _____

Department you would like to complete internship in: _____

Type of Internship Preference (Circle One):

1. Paid & Academic Credit
2. Paid & No Academic Credit
3. Not-Paid & Academic Credit
4. Not-Paid & No Academic Credit

Preferred time period of internship: _____

By my signature below, I confirm that I have read, understand, and agree to adhere to the conditions and policies of a Madison Regional Health System internship experience. I hereby agree that I will not disclose to anyone information concerning patients and patients' family members which I may acquire during the internship program.

_____ _____

Intern Signature Date

Submission Process:

Once completed, this application should be submitted, along with a cover letter and a current resume obtaining at least three references to Donna.Lueth@madisonhospital.com

Please Note: We will make every effort to reply to your request within 30 days.