

Horry County
Human Resources Department
PO BOX 997
1301 Second Avenue
Conway, SC 29526



Phone: (843) 915-5230
Fax: (843) 915-6230

UNPAID STUDENT INTERNSHIP APPLICATION

INSTRUCTIONS: Please answer all questions. Please Print using ink. SUBMIT APPLICATION TO HUMAN RESOURCES. THIS APPLICATION MUST BE ACCOMPANIED BY A PARENTAL CONSENT FORM

NAME _____
(LAST) (FIRST) (MIDDLE)

RESIDENCE _____

DATE OF BIRTH _____

HOME PHONE _____

CELL PHONE _____

EMERGENCY CONTACT NAME _____
TELEPHONE _____

TEACHER CONTACT NAME _____
TELEPHONE NUMBER _____

UNPAID INTERNSHIP YOU ARE APPLYING FOR: _____
GENERAL DESCRIPTION OF DUTIES YOU ARE SEEKING TO PERFORM:

DAYS AND HOURS AVAILABLE TO WORK: _____
DATES INTERNSHIP WILL BE IN EFFECT _____

WILL YOU BE SEEKING ACADEMIC CREDIT FOR THIS INTERNSHIP? YES ___ NO ___

DOES YOUR SCHOOL PROVIDE TIME CARDS OR LOGS FOR ATTENDANCE? YES ___ NO ___

DOES YOUR SCHOOL PROVIDE EVALUATION FORM OR PROGRESS REPORTS? YES ___
NO ___

Have you ever been convicted of a crime? YES ___ NO ___
If yes, please provide details _____

Applicant Certification: I CERTIFY that the statements made by me in this application are true, complete, and correct.

STUDENT SIGNATURE

DATE

Horry County
Human Resources Department
PO BOX 997
1301 Second Avenue
Conway, SC 29526



Phone: (843) 915-5230
Fax: (843) 915-6230

HORRY COUNTY PARENTAL CONSENT FORM

YOUR CHILD HAS APPLIED FOR AN UNPAID STUDENT INTERNSHIP POSITION WITH HORRY COUNTY GOVERNMENT. YOUR SIGNATURE ON THIS FORM INDICATES YOUR CONSENT OF YOUR CHILD'S PARTICIPATION IN THIS PROGRAM, AND ACKNOWLEDGEMENT OF THE INFORMATION CONTAINED HEREIN.

UNPAID STUDENT INTERNS ARE UTILIZED IN A VARIETY OF CAPACITIES IN HORRY COUNTY. YOUR CHILD WILL HAVE A GENERAL DESCRIPTION OF DUTIES IN CONNECTION WITH HIS/HER INTERNSHIP PROGRAM. PLEASE REVIEW THIS INFORMATION PRIOR TO SIGNATURE OF THE PARENTAL CONSENT FORM.

SHOULD IT BE NECESSARY FOR YOUR CHILD TO RECEIVE MEDICAL TREATMENT WHILE PARTICIPATING IN THIS INTERNSHIP, THIS FORM GIVES HORRY COUNTY GOVERNMENT STAFF PERMISSION TO USE THEIR JUDGMENT WITH REGARD TO OBTAINING OR REFERRING YOUR CHILD FOR MEDICAL SERVICES. PLEASE MAKE CERTAIN THAT YOUR CHILD HAS MEDICAL INSURANCE INFORMATION IN THEIR POSSESSION IN CASE OF EMERGENCY.

THE UNDERSIGNED PARENT OR GUARDIAN HEREBY FREELY AND VOLUNTARILY AGREES TO RELEASE, INDEMNIFY AND HOLD HARMLESS HORRY COUNTY GOVERNMENT, ITS EMPLOYEES, AGENTS AND REPRESENTATIVES FROM ANY AND ALL DAMAGES OF ANY NATURE WHATSOEVER WHICH THE UNDERSIGNED MAY SUFFER OR INCUR ARISING OUT OF THEIR CHILD'S PARTICIPATION IN AN INTERNSHIP PROGRAM WITH HORRY COUNTY GOVERNMENT.

PRINTED NAME OF STUDENT _____

PRINTED NAME OF PARENT/GUARDIAN _____

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

If you require further information, please contact Horry County Human Resources at 843-915-5230