



**Levine Children's Hospital Child Life Department
Practicum Applicant Check List**

Child Life Practicum Coordinator
Levine Children's Hospital
Room 2034
1000 Blythe Blvd.
Charlotte, NC 28203

- Completed Application
 - *Applications must be typed. Handwritten application will not be accepted.*
- Cover Letter
- Resume
- I verify that I am currently enrolled in a College or University that has an existing affiliation agreement with Atrium Health.
 - *Please verify with your academic advisor.*
- Verification of volunteer experiences (please use one form per experience)
 - *A minimum of 80 hours of volunteering required. 40 hours working with typically developing children and 40 hours working with either children who have been hospitalized or atypically developing children.*
- Unofficial transcripts from most recent academic institution, verifying 3.0 GPA in major
 - *Student copy is acceptable.*
- List of Relevant Child Life Coursework in your major or completed in the last year.
 - *Please refer to the Association of Child Life Professionals List of Accepted Courses.*
- Two signed letters of recommendation—One must be from a professional who has observed you working directly with children.
 - *Letters do not need to be in envelopes but must be signed.*
- Signed application checklist

By signing, I indicate that I have reviewed and met the application requirements. I am submitting all necessary documentation to be considered for a child life practicum experience at Levine Children's Hospital.

Signature: _____

Date: _____



**Levine Children's Hospital Child Life Department
Practicum Applicant Information Sheet**

For your application to be considered, applicant information *must* be typed.
Handwritten/scanned documents are not accepted.

Session Applying for: ____ Year ____ Summer ____ Winter

Personal Information

Name:			
Present Address:			
Permanent Address:			
E-mail Address:			
Phone Number:			

Emergency Contact

Name:			
Relationship:			
Address:			
Phone Number:		Alternate Phone Number:	

University Affiliation

<u>University Name:</u>			
Address:			
<u>Advisor Information</u>			
Name:			
Phone Number:			
E-mail Address:			



Academic Information

Please list information for all universities and colleges attended

University Name:			
Major:			
GPA – Cumulative:		GPA in Major:	
Graduation Date:			

____ Bachelors ____ Masters

University Name:			
Major:			
GPA – Cumulative:		GPA in Major:	
Graduation Date:			

____ Bachelors ____ Masters

University Name:			
Major:			
GPA – Cumulative:		GPA in Major:	
Graduation Date:			

____ Bachelors ____ Masters

What days and times are you available to fulfill practicum hours? *(Please keep in mind we will offer shifts Monday-Sunday depending on staff availability. Some shifts could be weekends or evenings until 9:00pm.)*

What other commitments will you have during your practicum?

I understand it is the sole responsibility of the applicant to confirm receipt of application packet. I understand if my application packet is incomplete, I will not be considered for the practicum program.

Signature

Date



**Levine Children's Hospital Child Life Department
Practicum Questionnaire**

Please type between 100-200 words.

1. How did you become aware of the field of Child Life? What have you done thus far to increase your knowledge and awareness of the child life profession?
2. What strengths (skills and talents) would you bring to the child life practicum?
3. What aspects of working with children do you need to improve upon?
4. Describe a time that you used play to support the needs of a child.
4. What are your expectations and goals of a child life practicum placement?



**Levine Children's Hospital Child Life Practicum
Association of Child Life Professionals Relevant Coursework List**

(All courses listed must be present on unofficial transcripts)

Courses must be submitted through the Association of Child Life Professionals website for verification.

Course Number and Title <i>(i.e. Child Development)</i>	Where <i>UNCC</i>	Year <i>2017</i>	Term <i>Spring</i>	Grade <i>A</i>
1.				
2.				
3.				
4.				
5.				



**Supervised Hours Working with Children
Verification Form**

(Applicant: This form is to be completed by all places from which you are submitting hours.)

I confirm that (applicant) _____ has completed _____ hours at
(Institution) _____ in (location) _____ working with:

(Type of experience – check one)

- Working with children who are physically well/typically developing
- Working with children in a healthcare or stress-related environment
- Working with children with intellectual/physical delays

The applicants experience consisted of the following responsibilities (list typical types of interactions with children):

Signature/Credentials: _____

Printed Name: _____

Title: _____

Date: _____

Phone Number: _____