The Athens Neighborhood Health Center

PHARMACY SERVICE LEARNING APPLICATION

Name: _____
First *Middle Initial* *Last*

Email Address: _____ Date of Birth: _____ Gender**:** ___ M ___ F

Local Mailing Address:
Street Address_____ Apartment #: _____
City _____State _____ Zip_____
Valid until: _____ Phone # _____ Cell# _____

Permanent Address (if *different from above):*
Street Address_____ Apartment #: _____
City _____State _____ Zip_____
Phone # _____ Alternate Phone#_____

Academic Information:

Classification: _____Expected Date of Graduation (Month and Year):_____
(Ex. 1st, 2nd, 3rd year)

General Information

How did you hear about our program? _____
_____

What do you expect to gain from our program? _____
_____
_____
_____

Hours required to complete requirement: _____

Availability

Date Available to Start _____ Time Period_____ End Date _____
(Ex. Summer, Fall, or Spring)

Hours of Availability

Monday	Tuesday	Wednesday	Thursdays	Friday

Hours must be during normal business hours, which are from 8am – 5:00pm on Mon, Wed and Thurs. Hours are from 8am – 7pm on Tuesday's and 8am -2pm on Fridays.

Once you have completed this application please email:
Jennifer Richardson at jrichardson@aneighbor.org.
Title the email Pharmacy Internship Application and attach BOTH
Your APPLICATION and Your RESUME.
Contact Jennifer Richardson with any questions at (706) 255 - 4694