WHOLE HEALTH CLINIC
DONGGUK UNIVERSITY LOS ANGELES

Application for Clinic Internship

Name: _____ **Student ID:**_____

Date of Birth: _____ **Phone Number:**_____

Email: _____

Address:_____

Degree Program: □ MAcHM (Master's program) □ DAcHM (Doctorate program)

[A] Starting Internship Quarter and Year: _____ **/ 20**_____

[B] Emergency Contact Information

Name: _____

Phone Number:_____

Relations:_____

Address: _____

By submitting and signing this document, I acknowledge having received and read the DULA Whole Health Clinic Handbook (i.e. DULA WHC Handbook / OMC Handbook). I also acknowledge that I fully understood and will comply with the DULA WHC regulations as stated in the DULA WHC Handbook.

I certify that the information in this application is true and complete in all respects and that I have withheld no information. I understand that misrepresentation, falsification of documents, or withholding of requested information regarding this application are serious offences and may result in prosecution under the University's Codes of Behavior and/or Criminal Code of California.

Student Signature: _____ **Date**: _____

FOR OFFICE USE ONLY

Clinic Coordinator: _____ **Date**:_____

Please submit this form via e-mail to clinic.education@dula.edu.