Internship Agreement

Student: ________________________________
Program: ________________________________
Instructor: ________________________________

# of hours required to complete Internship (if applicable): ________

Employer: ________________________________
Address: ________________________________
Supervisor: ________________________________
Email: ________________________________
Telephone: ________________________________

SECTION I: Provide an outline of Internship objectives, directly related to the student’s program or occupational objective. (To be completed by Employer, what can the student expect to learn during this experience?)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

It is hereby agreed and understood by the Employer, Student and the Department Instructor that the minimum number of hours the student shall work during the occupational experience is 225 hours.

SECTION II: It is further agreed and understood by and between the Employer, Student and the Department Instructor that:

A. The student will submit this contract with the required signature to the WATC Career Services office prior to beginning the Internship.

B. The Employer agrees to submit Student Evaluation Forms, following every 75 hours of the occupational experience. A final Student Evaluation Form will be submitted at the conclusion of the occupational experience period addressing the student’s achievement of the objectives identified in Section I of this agreement.

C. The student shall submit a Work Schedule, signed by their supervisor and a Final Report of Hours and Wages to WATC’s Career Services Office at the end of the occupational work experience.
D. The Employer agrees to notify WATC’s Career Services Office immediately upon the release or reassignment of the student.

E. The Employer follows equal opportunity hiring practices and does not discriminate on the basis of race, color, religion, sex, national origin, ancestry or disability.

By:

__________________________________        ________________  
Career Services, Director  

__________________________________  
Student  

__________________________________  
Department Instructor  

__________________________________  
Employer

Date

Date

Date

Date

RETURN TO:  
Director of Career & Disability Services
316-677-9416
Wichita Area Technical College
4004 N Webb Rd
Wichita, KS 67226
Or
Email signed scanned forms to vsantiago@watc.edu
OCCUPATIONAL EXPERIENCE AGREEMENT

It is hereby understood and agreed by and between Wichita Area Technical College, (School)
__________________________________ and _________________________________ that:

(Student) __________________________ (Internship Employer)

The student is enrolled in a technical training program, taken for credit at Wichita
Area Technical College, a public education institution, and such occupational experience

Obtained through _________________________________ is an integral part of the student’s

(Employer) _________________________________

Education. The occupational work experience program was not established for or on behalf

of any employer or group of employers. The student understands and agrees that upon

Completion of the occupational work experience period the student shall not file for nor be

entitled to unemployment compensation because said occupational work experience is not


Dated this __________ day of _______________________, 20 __________

By _________________________________

WATC Administrator signature

Dated this __________ day of _______________________, 20 __________

By _________________________________

Student signature

Dated this __________ day of _______________________, 20 __________

By _________________________________

Instructor signature

Dated this __________ day of _______________________, 20 __________

By _________________________________

Employer signature
Notice of Nondiscrimination
The WATC Board of Directors supports and complies with Title VI and Title VII of the Civil Rights Act of 1964 as amended, Section 504 of the Rehabilitation Act of 1973 and Amendments, The Americans with Disabilities Act, Title IX and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services and the Department of Education. It is the policy of the Board of Directors that no person in the United States (on the grounds of race, color, religion, sex, national origin, ancestry or disability) shall be excluded from participation in, denied the benefit of or otherwise subjected to discrimination under any program or activity of, or employment with Wichita Area Technical College.

STUDENT EVALUATION FORM
(This form is to be completed and returned following every 75 hours of the occupational experience.)

Name of Student: _______________________________________________

Dates of Occupational Work Experience:
From: ______, 20____ Through: ________, ______
Numbers of Hours Worked: _________

Please rate the student on the following by placing an X in the appropriate place

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<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Poor</th>
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<tbody>
<tr>
<td>ATTENDANCE</td>
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<td>APPEARANCE</td>
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<td>BASIC KNOWLEDGE</td>
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What additional skills would be beneficial for the student to have to be successful in your Company? ______________________________________________
________________________________________________________________
________________________________________________________________

Comments: ______________________________________________________
________________________________________________________________
________________________________________________________________

Supervisor Signature: ________________________ Date: ________________

RETURN TO:
Director of Career & Disability Services
Wichita Area Technical College
4004 N Webb Rd
Wichita, KS 67226
Or
Email signed scanned forms to vsantiago@watc.edu
FINAL REPORT OF HOURS AND WAGES

Name of Student: __________________________________________

Employer’s Name & Address: __________________________________________

___________________________________________

___________________________________________

Dates of Occupational Work Experience:

From: ____________________________, 20 _____

Through: ____________________________, 20 _____

TOTAL HOURS WORKED IN THIS PERIOD: __________

TOTAL WAGES EARNED IN THIS PERIOD: __________

____________________  __________
Student Signature       Date

RETURN TO:
Director of Career & Disability Services
Wichita Area Technical College
4004 N Webb Rd
Wichita, KS  67226

Or

Email signed scanned forms to vsantiago@watc.edu