University of Nebraska Kearney  
Department of Communication Disorders Internship Agreement

Cooperating clinician _________________________ whose ASHA membership number is __________________________ with an expiration date of __________________________ and has at least three years of experience, agrees to supervise

UNK intern _________________________ at _______________________
   Student’s Name  Internship Site

for the assigned period of _________________________ to _________________________.
   Start Date  End Date

________________________________________
Email  Phone number  State License # (if applicable)

________________________________________
UNK Internship Coordinator  Cooperating Clinician

Please return this form along with a copy of your current ASHA card to the UNK Internship Coordinator on or before the first week of the internship. The intern cannot be placed without a signed agreement. A self-addressed, postage paid envelope is enclosed for your convenience.

(rev. 10-22-14)