

Professor Use Only

Internship Completed _____

Internship Agreement

Department of Applied Communication Studies- Southern Illinois University Edwardsville

Return this form (including your supervisor's signature) with your completed internship application to Dr. Sorin Nastasia, Director of Internships.

Email: snastas@siue.edu

Office: Alumni Hall, rm. 3112

Mail: Campus Box 1772, Edwardsville, IL 62026

Phone: 618.650.5826 Fax: (618) 650-2038

Student Information

Name: _____ Student ID Number: _____

E-mail: _____ Phone: _____

Local Address: _____

Major: _____ Minor: _____

Year in School: _____ Expected Graduation Date: _____

Course Registration Information

Semester: _____ ☐ ACS 491 (undergraduate) # of Credits (1-6): _____

☐ ACS 591 (graduate)

Internship Information

Organization: _____

Start Date: _____ (e.g. 9/1/2025) Ending Date: _____ (e.g. 12/15/2025)

Paid: ☐ No ☐ Yes \$ _____

Hours worked per week: _____

Job Description/Responsibilities/Examples of Work (Attach job description)

On-Site Supervisor Information

Name: _____ Title: _____

Phone: _____ Email: _____

Supervisor's Signature: _____ Date: _____