**INTERNSHIP AGREEMENT FORM**

**DEPARTMENT OF MATHEMATICS & COMPUTER SCIENCE**

**LONGWOOD UNIVERSITY**

Semester: Choose term. 20   Course: Choose prefix. 492

Student’s Name:

Address:

Address2:

Phone:

E-mail:

Sponsoring Firm:

Address:

Address2:

Organization Description:

Internship Supervisor:

Position/Title:

Phone Number:

E-mail:

**To the Internship Supervisor:** Upon completion of the Internship, please return the **Supervisor Evaluation of Student Intern**. The Supervisor Evaluation Form is confidential and will be used in deciding the grade that the student receives in the internship.

Please provide a **detailed description** of the intern’s roles and responsibilities:



Work Schedule: Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Sunday:

Beginning Date: Choose month.  , 20   Ending Date: Choose month.  , 20

Intern’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Supervisor’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Internship Director’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: