

INTERNSHIP AGREEMENT
Dept. of Communication
College of Charleston

Name: _____

Address: _____

Telephone/e-mail: _____

Academic Term: _____

Organization Name: _____

Address: _____

Field Supervisor: _____

Title: _____

Telephone/e-mail: _____

Hours of work per week: _____

Specific work schedule:

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Academic credit to be earned (to be completed by the internship director):

Nature of work to be performed by student:

Specific projects to be completed (if applicable):

Signature of student: _____

Date: _____

Signature of field supervisor: _____

Date: _____

Signature of internship director: _____

Date: _____

(Signed copies of this agreement are to be maintained by all three parties.)