**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: