



**MHA**  
MENTAL HEALTH ASSOCIATION  
in Niagara County, Inc.

## Internship Request

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

School or Institution: (Name and Location)

\_\_\_\_\_

Contact person Name: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Total hours needed: \_\_\_\_\_ No. of Hours requested from MHA: \_\_\_\_\_

Start date: \_\_\_\_\_ End date: \_\_\_\_\_

Projected hours per week: \_\_\_\_\_

Will your supervisor at MHA require any special credentials (degree): \_\_\_\_\_

\_\_\_\_\_

What are the responsibilities of the supervisor: (contact hours, documentation, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Type of work requested: (list specific tasks or programs you prefer or require)

\_\_\_\_\_

\_\_\_\_\_

Please return to:

Mental Health Association in Niagara County, Inc.

36 Pine Street

Lockport NY 14094

Or by email to [pszalay@mhanc.com](mailto:pszalay@mhanc.com)