

# Agency Selection Form

Intern Name: \_\_\_\_\_

**\*\*TO BE COMPLETED BY THE INSTITUTION UPON RECEIPT\*\***

Student's KUID #: \_\_\_\_\_ Student's SSN: \_\_\_\_\_

Student Federal Work Study Award for the 20\_\_-20\_\_ academic year: \$ \_\_\_\_\_

Student's Hourly Wages: \$ \_\_\_\_\_/hour  
(This will be paid solely through the University of Kansas Medical Center Federal Work Study and institutional funds.)

Total number of hours student is available to work \_\_\_\_\_ for the  year  semester  
(Divide the student's award amount by the hourly wage)

Agency Name: \_\_\_\_\_

Agency Mailing Address: \_\_\_\_\_

Supervisor Name: \_\_\_\_\_

Supervisor Phone #: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Brief Description of Agency: \_\_\_\_\_

Brief Description of Anticipated Work: \_\_\_\_\_

*By signing this contract, I \_\_\_\_\_ (as an authorized representative of the organization) certify that the student named on this contract will be employed at the Agency during the current academic year/term and that the student will be adequately supervised in order to ensure satisfactory job performance. I also understand and agree to adhere to all FWS policies and regulations as stated in the **Federal Work Study Community Service Program (FWSCSP) Participation Agreement** and will notify the FWS Coordinator of any changes in the student's employment status. I further understand that failure to do so may result in termination of our participation in the program.*

Agency Supervisor's Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Institution Liaison Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

FWS Coordinator Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_