



Application for Sib Internship Only siblings of people with disabilities who have completed at least one year of college are eligible to apply.

Name: _____ Date of Birth: _____

Street address: _____ City: _____ State: _____ Zip: _____

Cell phone: _____ Email: _____ (one you check at least daily)

College: _____ Graduation year _____ GPA _____

Race: _____ Gender: _____ County of residence _____ Driver's license #: _____

Name of sibling with disability _____ Age _____

Diagnosis or description of condition (cerebral palsy, non-verbal, cognitive delay, etc)

What degree or career are you pursuing?

Describe a project or responsibility you recently accomplished. Were you trying to change something? If so, what? What one lesson did you learn in the process of completing the project? (use the back if needed)

References: Please list the complete name, address, phone number of at least 2 adults with knowledge of your character, experiences and ability. **NO MORE THAN ONE RELATIVE.**

1. Name _____ Relationship: _____

Email: _____ Phone: _____

2. Name _____ Relationship: _____

Email: _____ Phone: _____

I HEREBY CERTIFY THAT ALL OF THE INFORMATION IN THIS APPLICATION IS CORRECT.

Your Signature _____ Date: _____

Thank you for applying. If you have any questions, please feel free to contact me.

Harriet Redman, executive director
920-968-1742 info@wisconsibs.org

[MAIL THIS APPLICATION TO WisconSibs, 211 E FRANKLIN ST, APPLETON, WI 54911](#)