The Second National Survey of U.S. Internship Standards in Health Education Professional Preparation: 15 Years Later

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ABSTRACT

This study assessed internships associated with health education professional programs in the U.S. This study updates findings from an earlier survey published in 1990. Using the 2003 AJHE directory of institutions, 255 health education professional preparation programs were identified. Two hundred and eleven institutions had a health education/promotion or community health program and were sent a survey packet. Of the 211 surveys sent, 124 completed surveys were returned. Results indicate that overall the vast majority of programs required internships. Undergraduate programs were more likely to require an internship than were masters level programs. Travel reimbursement for site visits was reported by most programs, as was inclusion of site visits in full-time faculty's workload; however, there was a decrease in the proportion of programs reducing workload to compensate for site visits from the first survey. Over half of programs have a policy in place regarding student compensation with almost 40% reporting that student compensation is allowable. Sixty-nine percent of the responding programs have a formal process for approving internship sites. The two most important criteria reported in approving an internship sites were types of work experience provided by the site and previous positive experiences with the site.

INTRODUCTION

In 1988, Cottrell and Wagner[1] conducted the first national survey of internships in community health education/promotion professional preparation programs. At the time, the authors found that internships were seen as an important component of most undergraduate and graduate programs and that supervision of such internships was adequate. Policies regarding reimbursement and course load reductions for site visits were presented. Few institutions had policies regarding salary and other compensation for student interns. The original study, published in 1990, also found that the majority of programs had a formal process for approving internship sites. When asked, original participants rated quality of supervisory staff, type of work experience provided and previous positive experiences with the site as the top three criteria in site selection. No studies have been published since 1990 to address community health education professional preparation internship standards.

The purpose of the present study was to assess current standards used by U.S. universities and colleges to approve and supervise internships in health education professional preparation programs. The survey was designed to answer the following questions: 1) How many programs require internships of their students? 2) Are site visits made during student internships? If so, who makes the visits? How are these included in a faculty member's workload? Are persons making site visits reimbursed for travel? 3) Can students receive pay and or living expenses during their internships? 4) Do

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Table 1. Geographical Distribution

AAHPERD Districts	Population of Institutions n	Population of Institutions %	Study Sample of Institutions n	Study Sample of Institutions %
Southern	76	36.0	48	38.7
Eastern	44	20.9	22	17.7
Midwest	35	16.6	26	21.1
Central	25	11.8	11	8.9
Southwest	19	9.0	10	8.1
Northwest	12	5.7	7	5.6
Total	211	100.00	124	100.0

formal procedures exist to approve/certify internship sites prior to student placement? And 5) what differences exist between graduate and undergraduate internship requirements and administrative procedures?

This follow-up study is significant because it provides up-to-date information about internship guidelines and requirements currently used by health education programs in the United States. This information may be useful to those involved in professional development and possibly those who volunteer to be health education internship sites. Further, when compared to the 1988 survey data, this information may provide interesting insight into how internships have evolved since then.

SUMMARY OF BACKGROUND

Recent studies have shown that internships are an important part of a student's professional development.[2,3,4,5] According to the literature, internships provide students many benefits. Internships offer students an opportunity to apply theory learned in the classroom to a real-world setting while developing important work-related competencies.[6] Sixty to 70% of students report that they prefer the experiential learning provided by an internship to traditional classroom lectures.[7]

Not only can internship programs be used to develop professional competencies,[8] but internships also can provide the opportunity to foster student leadership.[9] Internship experiences can expose students to different cultural and socioeconomic backgrounds and build cultural competency.[10,11] Internships may provide a vehicle for learning about, reflecting on, and understanding health disparities that can have an effect on later social justice-related behaviors of future professionals.[5] In a program with University of Florida first-year medical students, 90% of the participants felt their internship experience affected their career choice.[12] Ralston[13] reported that students participating in a mentoring model internship successfully entered health professions, either through job placement or through graduate or professional school placement.

In addition to the lessons learned by students through an internship experience, there are benefits for the college/university and community as well. Students who participate in mentoring model internships are more successful in entering the profession,[13] and student placement is an important indicator of program quality in many colleges and universities. Internships also provide participating organizations with free or low-cost temporary employees that may be able to complete projects that are beyond the time capacity of current employees. In addition, internships allow employers to work with, observe and help train interns that they may want to hire as full-time employees upon completion of the internship. In a case study at the University of Montana involving the Montana State Prisons, both groups perceived benefits from internship placements and intended to continue their intern relationship.[2] This sort of internship success helps build networks in the community for the university.[14] Often the student learns professional skills by solving a community problem, thus improving the community in which they are working.[12]

Despite the many benefits gained from internships, there are some barriers to implementing internship programs. Often the variety and number of agencies seeking interns are overwhelming and difficult to sort. This makes it difficult for students and administrators to know where students are best suited and most needed. An organizational model that classifies field placement, employment, and health care information with their related agencies, institutions, and organizations was prepared to alleviate this problem.[15] Problems may arise when the student or mentor is not properly informed of expectations. Careful preparation and communication between parties involved in the mentor or preceptor experience can well address this problem. Several frameworks have been developed to address these types of barriers.[16,3,17,18]

Cottrell and Wagner[1] published a study in which health education and health promotion programs were surveyed. They determined that 93% of the programs required internships of undergraduate students and 73% required graduate internships. During the past 15 years, many changes have taken place in health education and in professional preparation programs that may have affected the internship experience. No other study has been conducted to assess current practices in health education internship policies and procedures. One additional article was published in 2005 that presented internship planning and implementation guidelines for site supervisors, faculty coordinators, and intern students.[19]

METHODS

Participants in the present survey study were department heads, directors, or program coordinators at university or college Health Education programs listed in the 2003 American Association for Health Education (AAHE) *Directory of Institutions Offering Undergraduate and Graduate Degree*

Programs in Health Education.[20] In February 2005, letters of invitation were sent to the contact person at each institution listed as having a community health education/promotion program. The letters were accompanied by a four-page survey and a postage-paid envelope for convenience of return. A second mailing was sent to those who had not responded two weeks after the initial mailing.

THE INSTRUMENT

The survey instrument used in the present study was largely based on the original study instrument developed by Cottrell and Wagner.[1] A few questions were added to better understand program characteristics and the proportion of internship sites providing experiences with diverse communities. The updated survey instrument consisted of four sections addressing 1) program characteristics, 2) undergraduate internship guidelines, 3) masters-level internship guidelines, and 4) site selection criteria.

Categorical items were used in the first section to address program characteristics such as types of degrees offered and whether internships were elective, required or both. Categorical items were also used in the two sections in which undergraduate and graduate internship guidelines, respectively, were addressed. These sections produced information related to required length of the internship, type of personnel conducting internship site visits, typical number of site visits, travel support, and time reimbursement practices for personnel conducting site visits. Further, presence of formal approval processes for internship sites, student intern compensation policies, and proportion of internship sites providing exposure to multicultural and diverse communities were examined. The fourth section included eight items utilizing a Likert-type scale for ranking the importance of various characteristics in selecting and approving internship sites. The original seven-item scale was updated to include an item on the importance of the site supervisor's Certified Health Education Specialist (CHES) status. Participants could rank each of the eight listed criteria for both undergraduate and graduate programs on a four-point scale (1=Unimportant, to 4=Very Important). Operational definitions were provided as follows: Unimportant = does not have to be present to approve internship site; Less Important = nice if present to approve internship site; Important = should be present to approve internship site; and Very Important = must be present to approve internship site. An open-ended item allowed participants to list other criteria utilized in the internship site approval process.

Table 2. Percentage of Institutions Offering and/or Requiring Internship, Practicum or Service Learning by Graduate (n=71) and Undergraduate (n = 102) Level

Program Guidelines	UG		G	
	n	%	*n*	%
Offer but do not require				
Internship	11	10.8	7	9.86
Practicum	21	20.6	10	14.1
Service Learning	27	26.5	21	29.6
Require				
Internship	96	90.0	49	70.0
Practicum	30	29.4	30	42.3
Service Learning	25	24.5	10	14.1

RESULTS

The American Journal of Health Education Directory of Institutions[20] listed 255 programs. Of these, 211 were identified as having community health education or health promotion degree offerings. A total of 127 department heads, coordinators or chairs responded from qualifying institutions resulting in a return rate of 60.18%. Of these, 124 were complete and usable surveys resulting in a final rate of 58.76%. Using the American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD)[21] regional districts, it was established that the sample of 124 was geographically distributed as follows: Southern 38.7% (n=48), Midwest 21.0% (n=26), Eastern 17.7% (n=22), Central 8.9% (n=11), Southwest 8.1% (n=10) and Northwest 5.6% (n=7). This distribution was very similar to the distribution of the initial 211 institutions from the AAHE[20] directory that were asked to participate in the study: Southern 36.0% (n=76), Eastern 20.9% (n=44), Midwest 16.6% (n=35), Central 11.8% (n=25), Southwest 9.0% (n=19) and Northwest 5.7% (n=12) (Table 1).

Program Characteristics

The resulting sample size of 124 programs included 102 institutions that offered undergraduate programs and 71 that offered graduate programs. More specifically, 37.9% (n=47) of programs offered undergraduate degrees only, 18.5% (n=23) offered graduate degrees only, and 43.5% (n=54) offered both. The types of community health/health promotion degrees offered at the undergraduate level included B.S. (65.3%), B.A. (13.7%), B.Ed. (3.2%,) and "other bachelors degree" (7.3%). At the masters level, community health/health promotion degrees offered included M.PH. (25.2%), M.S. (24.4%), M.Ed. (12.2%), M.A. (9.8%), and "other masters degree" (11.3%).

Participants were also asked if their programs offered and/or required internship, practicum, and service learning experiences. Table 2 displays these results by type of degree offered. Operational definitions for each learning experience were provided. Internship was defined as "a culminating experience where students work/practice in their major field of study for academic credit"; practicum was defined as "a learn-

Table 3. Number of Site Visits by Undergraduate and Graduate Level

	UG		G	
Number of site visits	*n*	%	*n*	%
1 site visit	37	46.8	26	61.9
2 site visits	27	34.2	9	21.4
3 site visits or more	15	19.0	7	16.7
Total	79	100.0	42	100.0

ing experience prior to the culmination of one's academic program where students work/practice/observe in their major field of study for academic credit"; and service learning was defined as "a structured experience whereby students provide service to a health related agency for a specified time period and receive valuable experience and academic credit." As can be seen in Table 2, the most often required learning experience, at both levels, was the internship experience with 83.3% (n=85) of undergraduate and 74.6% (n=53) of graduate programs having this requirement. Only 10.8% (n=11) of undergraduate and 9.86% (n= 7) of graduate programs offered internships but did not require them.

Programs were also identified as being either a Category I or II Research Institution as classified by the Carnegie Classification of Institutions of Higher Education taxonomy of the U.S.[22] Thirty-three or 26.6% were Research I institutions and 14 or 11.3% were Research II institutions. The remaining 77 programs (62.0%) were not classified as either Research I or II.

Graduate & Undergraduate Internship Guidelines

The majority of the programs required an internship. Chi-square analyses revealed that undergraduate programs (n=96, 95%) were more likely than masters level graduate programs (n=49, 70%) to require internship experiences (χ^2=11.2, p=.001). Responses also indicated that 63.4% (n=64) of the undergraduate programs required one full term of internship/practicum experience. Nineteen percent (n=19) of undergraduate programs required less than one full term and 12.9% (n=13) required internship experiences lasting longer than one full term. Only 5.0% (n=5) of undergraduate programs required no internship/ practicum experience at all. At the graduate level, 30% (n=21) required one full term of internship/practicum experience, 27.1% (n=19) of graduate programs required less than one full term, and 12.9% (n=9) required internships longer than one full term. However, among graduate programs 30% (n=21) required no internship/ practicum experience at all.

Of the 124 programs in the sample, 80 (78.4%) undergraduate and 42 (71.2%) graduate programs reported that university personnel conduct internship site visits (Table 3). Graduate programs conducted significantly fewer site visits than undergraduate programs (t(41)=9.54, p=.000). Although the difference was statistically significant the difference in mean number of visits was fairly small. Undergraduate programs had a mean of 1.84 visits (SD=1.006) per term and graduate programs had a mean of 1.71 site visits (SD=1.175).

Roughly one-third of the programs had more than one person conducting site visits. In the majority of cases (92.5% Undergraduate [UG], 92.6% Graduate [G]) full-time faculty conducted the site visits. Financial reimbursement for travel expenses was common with approximately three out of four programs (79.5% UG and 74.4% G) responding that reimbursement was standard practice in their institution. However, 20.5% (n=16) reported that they were not reimbursed for internship site visit related expenses. Including site visits as part of a faculty member's workload was also found among most programs with 69.2% (n=54) of undergraduate programs and 72.1% (n=31) of graduate programs reporting this practice.

Program administrators were also asked about student compensation policies. These results were very similar across graduate and undergraduate levels. At the undergraduate level, 43.0% (n=43) reported that there was no policy in place regarding compensation for internships. Thirty-eight percent of programs had a specific policy that students could receive salary, living and travel expense compensation, while 16% percent of the undergraduate program administrators (n=16) reported policies that students could not receive any salary, living or travel expenses. At the graduate level, 45.9% (n=28) reported not having a policy in place regarding student compensation and 37.7% (n=23) noted a specific policy allowing student compensation. The remaining 14.8% (n=9) reported policies that students could not receive any compensation for internship experiences. As Table 4 indicates, there were no significant differences between undergraduate and graduate programs with regard to student compensation.

The survey also addressed the proportion of internship sites that provided experiences in community health/ health promotion with diverse/minority populations, such as ethnic and/or racial minorities, people with disabilities, immigrants, or non-English speakers. The majority of programs reported that more than half of their internship sites provided such diversity experiences for their interns (55.0% UG and 69.0% G).

Internship Site Selection Criteria

Approximately seven of ten program administrators reported having a formal process for approving or certifying potential internship sites (73.5% UG and 68.9% G). Participants in the study were asked to rate the importance of eight possible criteria that could be used in approving/certifying internship sites. Table 5 contains the mean rankings for both undergraduate and graduate internship sites. The top three criteria used in approving internship sites were 1) the types of work experiences the site could provide (most important for all pro-

Table 4. Chi-square Analysis of Student Internship Compensation Policies by Undergraduate and Graduate Program Offerings

	UG		G	
Policy	*n*	%	*n*	%
Students can receive salary plus living and travel expenses	38	38.0	23	37.7
Students can only receive living and travel expenses (no salary)	3	3.0	1	1.6
Students can receive no salary, living, or travel expenses	16	16.0	9	14.8
There is no policy regarding compensation for internship	43	43.0	28	45.9
Total	100	100.0	61	100.0
χ^2=.393 df=3 p=.942				

grams); 2) having had previous positive experiences with the site (second in importance for undergrad programs; third for grad programs); and 3) the number of staff at site to adequately supervise internship (third in importance for undergrad programs; second for grad programs). For both undergraduate and graduate programs, the importance of CHES certification for the site supervisor was rated sixth out of eight, and the ability of a site to pay students was rated as the least important criteria for site selection.

Intercorrelations

Programs that offered only a graduate degree were less likely to require an internship than graduate programs that also offered an undergraduate degree [$F(2,121)=13.81$, $p=.000$]. Programs offering only graduate degrees were also less likely to require service learning experiences than graduate programs with an undergraduate program [$F(2,121)=3.47$, $p=.034$]. It may be that the presence of an undergraduate program has some impact on graduate program curricula.

There was no significant difference in learning experience requirements between programs in institutions categorized as either Carnegie Research I or II. However, undergraduate programs from institutions categorized as Research II ranked the types of work experiences the site can provide as being more important in selecting internship sites than institutions categorized as Carnegie Research I [$F(2,98)=5.72$, $p=.004$].

Changes over time

Findings from the 1990 study by Cottrell and Wagner[1] were similar to the current findings in that undergraduate level programs are still more likely to have internship requirements than graduate programs. Site visits continue to be conducted primarily by full-time faculty. The faculty also seems to be reimbursed for travel expenses in a similar way to that reported in 1990.[1] Specifically, 77.5% of the undergraduate programs in the original study reimbursed their faculty for travel expenses and in 2005 that proportion was 80.0%. Among graduate programs, there was a slight decrease in the proportion of reported travel reimbursement from 77.3% in 1990 to 74.0% in 2005.

Another topic compared was the reported level of importance of selected criteria for approving or certifying internship sites, which was very consistent over the two studies. The three most important criteria in 2005 were found to be the same as in 1990[1], namely and in no particular order: the adequacy of the supervisory staff, the type of work experience, and previous positive experiences with the site. However, one difference in criteria rating was the addition of CHES certification to the original set of criteria and the fact that it was ranked number six in the 2005 sample. With regard to having a formal process by which a program certifies or approves an internship site, 69.0% of graduate program administrators in both the 1990[1] and the 2005 samples reported having a formal process in place for that purpose. At the undergraduate level the number of program administrators reporting a formal process increased from 66.0% in 1990 to 74% in 2005.

A fairly large difference was found between the proportion of current programs that consider site visits as part of a faculty's workload at both the graduate and undergraduate levels. At the undergraduate level it decreased from 77.0% in 1990[1] to 69.0% in 2005, while at the graduate level it decreased from 81.0% in 1990 to 72.0% in 2005. The mean number of site internship site visits did not differ among graduate and undergraduate levels in 1990.[1] However, in the 2005 study, there were significant differences in that undergraduate program administrators reported a higher mean number of site visits than did graduate program administrators.

DISCUSSION & IMPLICATIONS

Overall, it is very positive that the vast majority of undergraduate and graduate programs require internships and that most require internships of a full term or longer. These findings are similar to the 1990[1] findings. It is somewhat troubling though that all programs do not require an internship. The positive outcomes associated with internships such as practical experience, networking, job placement, and community involvement would seem to be an important aspect of any professional preparation program.[8,9,13] As the health education profession moves forward with program accreditation for undergraduate and

Table 5. Importance of Eight Criteria in Approving/Certifying Graduate and Undergraduate Internship Sites

Criteria	Undergraduate			Graduate		
	Rank	*Mean (SD)*	*n*	*Rank*	*Mean (SD)*	*n*
Types of work experiences the site can provide	1	3.84 (.993)	101	1	3.81 (.438)	62
Previous positive experience with the site	2	3.31 (.808)	102	3	3.23 (.818)	62
Number of staff at site to adequately supervise internship	3	3.22 (.740)	102	2	3.26 (.745)	62
Site supervisor holds Health Education/Health Promotion degree	4	3.02 (.844)	102	4	3.06 (.921)	62
Degree of autonomy afforded the student	5	2.77 (.705)	101	5	2.95 (.740)	61
Site supervisor has CHES certification	6	2.14 (.837)	101	6	2.05 (.895)	62
Geographic proximity to the University or College	7	2.01 (.933)	101	7	2.00 (1.00)	61
Site's ability to pay students during internship	8	1.29 (.497)	101	8	1.45 (.717)	62

Note: Unimportant= 1, Less Important= 2, Important= 3, & Very Important= 4.
Note: Rank 1 is highest, 8 is lowest.

graduate community health education programs, it will be important to include minimum internship requirements as part of the discussion. Most program administrators reported currently having the ability to provide internship experiences with diverse populations. This is thought to be an important aspect of the internship experience.[5,11,14] There is, however, much room for improvement in this area for health education programs. Forty-five percent of undergraduate programs reported that either none or less than half of their internship sites offer diverse population exposure or opportunities to their interns. The percentage was lower (31%), but still significant for graduate programs. As the diversity in our country continues to increase, it is of great importance that integral learning experiences, such as the internship, provide exposure to health education practice with diverse populations.

More than 65% of the administrators at both the graduate and undergraduate levels reported having a formal process for approving internship sites. However, it was surprising that 35% do not have a formal process. Does this mean that any agency can serve as an internship site and any individual, regardless of training, can serve as an internship supervisor? Again, as the health education profession moves forward with program accreditation for undergraduate and graduate community health education programs, minimum standards for internship sites may need to be part of the discussion.

Policies regarding compensation for student interns are certainly not consistent across the profession and this finding was similar in the 1990[1] study. Over half of all programs either do not have a policy or have a policy restricting students from receiving compensation. This may reflect the fact that most internship sites are voluntary or public health agencies that cannot afford to pay student interns. These results probably indicate that few health education interns are paid during their internships. If health education is to increase its acceptance and respectability as a health profession, there is a need to encourage and develop a more competitive compensation environment for our interns. This would come from adopting compensation policies that allow students to seek and obtain paid internships with agencies and organizations that still meet all of an institution's site selection criteria.

It is troubling to note that there was a decline in both graduate and undergraduate programs that consider site visits conducted by faculty as part of their workload. Perhaps this is indicative of the economic stressors confronting many colleges and universities that result in increasing faculty workloads. Nevertheless, effective supervision is very time consuming and faculty should be credited for their efforts.

SUMMARY

As in 1990[1], the vast majority of health education programs offer internships, but the internship requirement is not consistent across programs or degrees. Internship site selection criteria in use in 2005 are very similar to the site selection criteria used in 1990[1]. Some programs indicate, however, that they have no formal criteria for selecting internship sites. Over half of all programs noted that they have internship sites that will expose students to diverse populations. Most programs use faculty for site supervisions, compensate faculty financially for site supervision costs, and provide release time for conducting site supervision. Most programs either have no policy or have a policy that prevents students from receiving compensation during their internship.

Profession-wide conversations concerning internship requirements are needed and should be incorporated in future accreditation discussions. As seen in other health professions, strong placement opportunities for both prospect interns and graduating students are a significant benefit associated with internships. In order for the profession to continue to build academically and experientially strong internship experiences, further research is needed. Issues that could be addressed with future research include more detail on number of credit hours and duration of internships across programs,

pre-internship preparation expectations and requirements, skills expected during these culminating experiences, and a better understanding of possible links between internships and subsequent successful employment of graduating health educators. In addition, it would be helpful to conduct surveys or interviews with internship site supervisors and health education students completing the internship experience to obtain their perspectives on the effectiveness of internships and how internships could be improved. Given the already strong emphasis on internships in health education professional preparation programs, this additional information could only help to enhance these important learning experiences.

REFERENCES

1. Cottrell RR, Wagner DI. Internships in community health education/promotion professional preparation programs. *Health Educ.* 1990; 21(1):30–33.

2. Amtmann J. Perceived effects of a correctional health education service-learning program. *J Correctional Educ.* 2004; 55(4):335–348.

3. Kemper KA, Dye CR, Sherrill WW et al. Guidelines for Public Health Practitioners Serving as Student Preceptors. *Health Promot Pract*. 2004; 5(2):160–174.

4. Greenberg JS, Howard D, Desmond S. A community-campus partnership for health: The Seat Pleasant- University of Maryland health partnership. *Health Promot Pract*. 2003; 4(4):393–402.

5. Ottenritter NW. Service learning, social justice, and campus health. *J Am Coll Health.* 2004; 52(4):189–191.

6. Gibala D, Stuhldreher W. The internship as a capstone experience: The bridge from academia to practice. *Link*. 2001; 15(2):5–10.

7. Blumenthal DS, Jones A, McNeal M. Evaluating a community-based multiprofessional course in community health. *Educ Health.* 2001(14):252–255.

8. McKenzie JF. Professional preparation: Is a generic health educator really possible? *Am J Health Educ.* 2004; 35(1):46–49.

9. Grande D, Srinivas S. Student leadership and activism for social change in the US. *Educ Health.* 2001; 14(2):198–206.

10. Moranetz C, Hammig B, Moore W et al. The program: The community health project: An effective service learning experience for medical and MPH students. *Health Educ Behav.* 2001; 28(2):125–129.

11. Flannery D, Ward K. Service learning: A vehicle for developing cultural competence in health education. *Am J Health Behav.* 2002; 23(5):323–331.

12. Davidson RA. Community-based education and problem solving: The community health scholars program at the University of Florida. *Teaching & Learning in Medicine*. 2002; 14 (3):178–182.

13. Ralston PA. Diversifying the health professions: A model program. *Am J Health Behav*. 2003; 27(3):235–245.

14. Moranetz C, Hammig B, Turkmani D et al. Bridging the gap between public health and medicine: An analysis of the community health project. *Am J Health Educ*. 2004; 35(4):242–245.

15. Galli N, Corry JM. An organizational model of community health agencies for health education internships. *Health Values: Achieving High Level Wellness.* 1987; 11(6):15–24.

16. Oliver C, Appleton P. Mentoring for professional development in health promotion: A review of issues raised by recent research. *Health Educ*. 2002; 102(1):30–39.

17. Cauley K, Canfield A, Clasen C et al. Service learning: Integrating student learning and community service. *Educ Health*. 2001; 14(2):173–181.

18. Clark PG. Service-learning education in community-academic partnerships: Implications for interdisciplinary geriatric training in the health professions. *Educ Gerontology.* 1999; 25(7):641–660.

19. Rees KS, Thompson SE. An ounce of prevention... Internship planning and implementation for students, university advisors and site supervisors. *Californian J Health Promot.* 2005; 3(3): 1–7.

20. American Association for Health Education. Directory of institutions offering undergraduate and graduate degree programs in health education. *Am J Health Educ*. 34(4): 219–235.

21. Personal conversation with Eric Berkowitz, Director of Membership, American Alliance for Health, Recreation and Dance, August 26th, 2005.

22. The Carnegie Foundation. *Carnegie Classification of Institutions of Higher Education taxonomy of the U.S., 2000*. Available at: http://www.carnegiefoundation.org. Accessed July 26, 2005.