

## To be completed by the student:

Name:	
Street Address:	City:
State: Zip:	_ Email:
Telephone Number:	Cell:
Name of the School you are atten	ding:
Anticipated dates for Internship: _	
Course of Study/Area of Interest_	
Reason for Internship:	
School Requirement/Recommend	lation Other:
Name of School Instructor/Adviso	r
Telephone Number of School Inst	ructor/Contact
Complete Orientation Post Test	General Orientation Validation Checklist
Corporate Compliance Validation	Form Confidentiality Agreement
PA Patch (Crim Check)	Act 73/33 Clearances
<u> </u>	quest for clearances, choose "Employment" as the purpose or "Other" will not be accepted.
2 step PPD/ Mantoux or QuantiFE	RON tb-Gold Rubella Titer
Hepatitis B Vaccine or Declination	Form Flu Vaccine Proof Varicella
Written verification of a health ex	am



Verify with School that CURRENT copies are on file at the Hospital:
Proof of Liability Insurance: Copy of School Contract with UPMC:
Under the terms of this internship, it is understood that the student is under the direct
supervision of a Department Manager/Director. Any patient care delivered by the student will
be under the direction of the department manager or his/her designee and only after student
competency has been established and possession of school/personal liability insurance has bee
confirmed. The Department Manager will secure informed consent from the patient to permit
the student to participate appropriately in the provision of patient care. The student
understands and accepts the internship experience as described above. The student agrees to
abide by the rules and regulations of UPMC Horizon/UPMC Jameson.
Student Signature:Date:
OFFICE USE ONLY
Paperwork Received/(Date)(Signature)
Spreadsheet Notification Requirements Completed://