UPMC Horizon

Student Internship Application

To be completed by the student:

Name: ____

Street Address: ____

City: ______________________________**State:** __________ **Zip:** ______________

Email: ____

Telephone Number: ____________________ **Cell:** ____________________

Name of the School you are attending: ______________________________

Anticipated dates for Internship: ______________________________

Course of Study/Area of Interest: ______________________________

Reason for Internship: ______________________________

School Requirement/Recommendation: ______________________________

Name of School Instructor/Advisor: ______________________________

Telephone Number of School Instructor/Contact: ______________________________

- *Under the terms of this internship, it is understood that the student is under the direct supervision of a physician or 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 been confirmed. The physician or Department Manager will secure informed consent from the patient to permit the student to participate appropriately in the provision of patient care. Physicians will*

accept total responsibility for supervising and directing those students who wish to serve internships with them in the Hospital.

- *The student understands and accepts the internship experience as described above. The student agrees to abide by the rules and regulations of UPMC Horizon.*
- *The student understands that all requirements listed on the Internship Checklist must be submitted prior to beginning the internship.*

Student Signature: ____

Date: ____/____/____

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OFFICE USE ONLY

Paperwork Received: ____/____/____

Signature: ____

Spreadsheet: ______ Notification: ______ Requirements Completed: ____/____/____