

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 _____

Name of School Instructor/Advisor _____

Telephone Number of School Instructor/Contact _____

Verify with Instructor/Advisor that **current** Liability Insurance is on file _____

All requirements listed on the website have been completed and returned to the school's
instructor/advisor _____

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 been 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: _____