UPMC Northwest

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 _____ Other:_____

Name of School Instructor/Advisor_____

Telephone Number of School Instructor/Contact_____

Confidentiality Agreement _____ PA Patch (Crim Check) _____

Act 73 Clearance _____ Act 33 Clearances _____ _____

*When submitting your request for clearances, choose “Employment” as the purpose of the clearance. “Volunteer” or “Other” will not be accepted.

Covid vaccine proof_____ _____

UPMC Northwest

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 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 Northwest.

Student Signature: _____Date: _____

OFFICE USE ONLY

Paperwork Received___/____/_____ (Date) _____ (Signature)

Spreadsheet ____ Notification ____ Requirements Completed: __/__/___