Reset

OVERLAKE MEDICAL CENTER

Student Internship Application

Name _____ Date of Application _____

Local Address _____

E-mail _____ Day Phone

School of Affiliation _____

Internship Course _____

Academic Major _____ Year in School _____

Faculty Supervisor _____ Phone _____

What is your goal for this Internship?

_____

_____

_____

Please list 3 specific objectives for your Internship experience.

1. _____
2. _____
3. _____

Total clock hours intended _____ Start Date _____ End Date _____

In case of emergency, please contact: _____

Name _____

Phone _____ Relationship

Free Parking with student ID available in the 1100 116th Avenue NE Employee Parking Garage

PRIOR TO INTERNSHIP Overlake Medical Center MUST HAVE:

- ❑ Signed Affiliation Agreement
- ❑ Signed Confidentiality/Health Care Coverage Statement
- ❑ Student Intern Application
- ❑ Employee Health Clearance for Students from schools that do not place clinical groups at Overlake Medical Center, i.e. MMR, Chickenpox, Hep B, current TB

Unit _____ Shift _____ Manager _____

Date Approved _____

Please return to: Clinical Education | p 425-688-5882 | f 425-688-5290
Overlake Medical Center | 1035 116th Avenue NE, Bellevue, WA 98004