Internship/Externship Request Form

Please mail or fax information to:
Pocono Medical Center
Human Resources Development
2 Storm Street
Stroudsburg PA 18360
Phone Number: 570-426-6890, Option 1
Fax: 570-426-6682

The information on this form is needed to process an internship request in clinical areas at Pocono Health System. If you have any further questions, please contact HR Development at 570-426-6890.

*Please type or print clearly.

PERSONAL INFORMATION:

Name: __________________________________________ Date: ______________________

Email Address: ________________________________ Telephone Number: ________________

Have you ever been employed by or volunteer at Pocono Health System: □ Yes □ No
If Yes, please provide: Dates of Employment: ____________________________ Department: ________________

SCHOOL INFORMATION:

College/University: ____________________________________________________________

Program/Major: _______________________________________________________________

Current School Status: □ Freshman □ Sophomore □ Junior □ Senior □ Graduate

School Advisor/Internship Coordinator: __________________________________________

Advisor’s Phone Number: ____________________________ Advisor’s Email Address: ________________

Current GPA: __________________________

REQUEST:

If you have already arranged or secured an observation with a Pocono Medical Center employee or department, please list their contact information below:

Employee Name: ____________________________ Job Title: ____________________________

Department: ____________________________ Phone Number: ____________________________

Please list dates the employee or department committed to hosting for an internship: ________________
Please list the department or area of interest:

First Choice: ________________________________________________________________

Second Choice: ______________________________________________________________

Hours Needed Weekly _______________________ Total Hours Required: ___________________

Anticipated Start Date: _________________________ Anticipated End Date: _______________________

Anticipated Graduation Date: _______________________ Is this a school requirement? □ Yes □ No

MATERIALS TO BE FORWARDED TO THE ABOVE ADDRESS PRIOR TO INTERNSHIP PLACEMENT APPROVAL:

Please make sure all of the following is attached when sending the application.

□ Recommendation from professor/school advisor

□ Resume

□ Brief statement of interest explaining the desired goals and outcome of the internship

□ Copy of Driver's License or Other Proof of Identification

□ Proof of Flu Shot (Required for the months of October 1 – April 30 - depending upon duration of Flu Season)

Please initial:

_____ I agree to participate in Training, including Orientation, Job-Specific Instruction, and in-services determined necessary by the Medical Center.

_____ I agree not to discuss or divulge Confidential Information I may learn about the Medical Center's business, staff, patients, visitors, volunteers or other associates.

_____ I agree to abide by all Policies and Procedures of the Medical Center.

_____ I understand that if an Identification Badge or any other Medical Center property is issued to me, it is the property of the Medical Center, and I agree to return it upon leave of absence, termination of internship or whenever requested by staff to do so.

APPLICANT AGREEMENT:

I have read the application and hereby certify that all information provided in this request is accurate, and that submission of this request does not guarantee placement. I further understand that approval and placement of an internship is at the discretion of Pocono Medical Center.

_________________________________________       ___________________________       _____/______/______
Applicant Printed Name   Applicant Signature   Date