

**CORTLAND REGIONAL MEDICAL CENTER**  
**P.O. Box 2010 • 134 Homer Avenue**  
**Cortland, NY 13045 • 607-756-3585**



**STUDENT INTERNSHIP APPLICATION**

**Please complete this form and email to [tmurdough@cortlandregional.org](mailto:tmurdough@cortlandregional.org)**

**Thank you for your interest in an internship or shadowing experience at Cortland Regional Medical Center. Please be sure to fill out the application and be clear about your goals & objectives and the department you would like to be assigned. Once the Education Department receives your application, it will be forwarded to the department of interest for their review.**

Name: \_\_\_\_\_

Date of Application: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

School: \_\_\_\_\_

Internship Course: \_\_\_\_\_

Academic Major: \_\_\_\_\_ Year in School: \_\_\_\_\_

Faculty Supervisor: \_\_\_\_\_ Phone: \_\_\_\_\_

CRMC Department of interest:  
\_\_\_\_\_

What is your goal for this internship?  
\_\_\_\_\_

Please list your specific objectives for your internship experience:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Total clock hours intended: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

- 1. Signed Affiliation Agreement and Liability Statement (see school fieldwork supervisor)**
- 2. Occupational Health Clearance: You will be required to submit proof of the following information to the CRMC Occupational Health Office before you will be allowed to start your internship. This should be done at least two weeks prior to your anticipated start date.**

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**Fax: 607-756-3747**



Once you are accepted as an intern, you can either complete this form including the physician signature or provide documentation of all the following information to the CRMC Employee Health Department.

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

PHONE: \_\_\_\_\_ DEPT: \_\_\_\_\_

**\* Proof of the following must be provided prior to beginning internship. \***

• **Physical required within 1-year – Please attach copy of physical.**

• **Required Immunizations:**

<b>TETANUS (Tdap)</b> Must be within the past 10 years.	<b>DATE</b>			
<b>TUBERCULOSIS</b> Chest X-ray and report of results is required if past or current test is positive. (Prior BCG vac is not a contraindication for testing).  <p style="text-align: center;"><b>OR</b></p> PPD (2 step ppd if none within last 12 months)  <p style="text-align: center;"><b>OR</b></p> Two PPDs – 1 year apart	<b>Date of chest x-ray</b> _____ <b>Read by:</b> _____  <b>Date:</b> _____ <b>Date:</b> _____ <b>Lot #: _____ Exp Date: _____</b> <b>Lot #: _____ Exp Date: _____</b> <b>Result: _____</b> <b>Result: _____</b> <b>Read By: _____</b> <b>Read By: _____</b>			
<b>MMR (Measles, Mumps and Rubella)</b>  <b>Required for males as well as females.</b> <b>Rubeola = regular measles</b> <b>Rubella = German measles</b>	<b>* Meet one of these requirements:</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <b><u>OPTION 1</u></b>  <b>Two (2) MMR'S</b>            DATE _____            and            DATE _____         </td> <td style="width: 33%; vertical-align: top;"> <b><u>OPTION 2</u></b>  <b>Positive Rubella titer</b>            DATE _____            and            Positive Rubeola titer            DATE _____            Positive Mumps Titer            DATE _____         </td> <td style="width: 33%; vertical-align: top;"> <b><u>OPTION 3</u></b>  <b>One (1) MMR</b>            DATE _____            and            Positive Rubeola titer            DATE _____         </td> </tr> </table>	<b><u>OPTION 1</u></b> <b>Two (2) MMR'S</b> DATE _____ and DATE _____	<b><u>OPTION 2</u></b> <b>Positive Rubella titer</b> DATE _____ and Positive Rubeola titer DATE _____ Positive Mumps Titer DATE _____	<b><u>OPTION 3</u></b> <b>One (1) MMR</b> DATE _____ and Positive Rubeola titer DATE _____
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<b>PROOF OF RUBELLA IMMUNITY</b> <b>(if born before 1957)</b>	<b>VACCINATION _____ or TITER : _____ OR</b> <b>Physician document of disease</b>			
<b>HEPATITIS B SERIES</b>	<b>DATES</b> _____ <b>TITER</b> _____			
<b>VARICELLA (VZV)</b>	<b>HISTORY OF DISEASE:</b> _____ <b>TITER:</b> _____ <b>VACCINATION:</b> _____			

\_\_\_\_\_  
 Physician Name (Printed)

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date