**SUMMER INTERNSHIP
 College Students Only**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

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

 *Street Address City State Zip Code*

Home Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Work Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Cell Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred method of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of College/University you are attending and year in school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*\*Please note Twin Cities Orthopedics’ summer internship program will consist of both shadowing our physicians and participating in research related activities.\*\*\**

***Minimum*** number of hours required ***per week***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hours

How long are you looking to intern with our group? \_\_ (circle one) DAY(S) WEEK(S) MONTH(S)

Date range for interning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ -- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle who you are interested in observing:

PRIMARY CARE DOCTOR ORTHOPEDIC SURGEON

Please circle what you are interested in observing: SURGERY CLINIC BOTH

Please check next to each day of the week what time of day works best for shadowing/interning with our group:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| MON |  | AM (8 AM-NOON) |  | PM (1-5 PM) |  | NOT AVAILABLE THIS DAY OF WEEK |
| TUES |  | AM (8 AM-NOON) |  | PM (1-5 PM) |  | NOT AVAILABLE THIS DAY OF WEEK |
| WED |  | AM (8 AM-NOON) |  | PM (1-5 PM) |  | NOT AVAILABLE THIS DAY OF WEEK |
| THURS |  | AM (8 AM-NOON) |  | PM (1-5 PM) |  | NOT AVAILABLE THIS DAY OF WEEK |
| FRI |  | AM (8 AM-NOON) |  | PM (1-5 PM) |  | NOT AVAILABLE THIS DAY OF WEEK |

Are there are specific requirements that you need to fulfill from your school? (circle one) YES\* NO

***\*If yes***, please state the requirements or attach the requirements from your school to this form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**~ CONTINUED ON BACK ~**

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**CONFIDENTIALITY STATEMENT**

During this observation time I understand patient’s individual health information which is disclosed is confidential. I may become aware of this information via written, oral or electronic data. Twin Cities Orthopedics expects that any discussion, access, storage, interpretation, release or handling of this confidential information will be treated with care and caution.

By signing below- I understand this is an agreement set forth for the date range shown on the front page and I also understand the Confidentiality Statement.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/20\_\_\_\_\_

 *Shadowing/Interning Student’s Signature*

**EMERGENCY CONTACT INFORMATION**

Information of individual to contact in the event of an emergency:

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Work Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

Cell Phone: \_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_

**Please tell us why you are interested in becoming a Summer Intern at Twin Cities Orthopedics**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach your resume with this document.**

Qualified applicants will be asked to have a phone interview or/and an in-person interview in early Spring.

**Return completed form to:**

Twin Cities Orthopedics Attn: Research Department

4010 West 65th Street | Edina, MN 55435

Phone: 952-456-7136 | Fax: 952-944-0460

Email: Research@TCOmn.com