MOSMI
Minnesota Orthopedic Sports Medicine Institute
TWIN CITIES ORTHOPEDICS

HIGH SCHOOL/COLLEGE INTERNSHIP/SHADOWING REQUEST

Full Name: ____ DOB: ____/____/_______

Address: ______________________________ ____________________ ________ ____________
Street Address *City* *State* *Zip Code*

Home Phone: (_____) _____-________ Work Phone: (_____) _____-________ Cell Phone: (_____) _____-________

E-mail Address: ________________________________ Preferred method of contact: ____________________

Name of High School/College you are attending and year in school: ________________________________

****Please note Minnesota Orthopedic Sports Medicine Institute will allow you to intern/shadow no more than 40 hours over a three (3) week time period.****

Minimum number of hours required ***per week***: ____________________ hours

How long are you looking to shadow/intern with our sports medicine group? _____ (circle one) DAY(S) WEEK(S) MONTH(S)

Date range for shadowing/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:

MONDAY:	□ AM (8 AM-NOON)	□ PM (1-5 PM)	□ NOT AVAILABLE THIS DAY OF THE WEEK
TUESDAY:	□ AM (8 AM-NOON)	□ PM (1-5 PM)	□ NOT AVAILABLE THIS DAY OF THE WEEK
WEDNESDAY:	□ AM (8 AM-NOON)	□ PM (1-5 PM)	□ NOT AVAILABLE THIS DAY OF THE WEEK
THURSDAY:	□ AM (8 AM-NOON)	□ PM (1-5 PM)	□ NOT AVAILABLE THIS DAY OF THE WEEK
FRIDAY:	□ AM (8 AM-NOON)	□ PM (1-5 PM)	□ NOT AVAILABLE THIS DAY OF THE WEEK

Are there are specific requirements that you need to fulfill from your school/program? (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. Minnesota Orthopedic Sports Medicine Institute/ 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

If student is a minor (under the age of 18), parent signature needed:

Signature: ____ Date: ____/____/20____
Parent/Guardian'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: (_____) _____-________

Return completed form to:
Minnesota Orthopedic Sports Medicine Institute at Twin Cities Orthopedics
Attn: Becky Stone
4010 Wet 65th Street
Edina, MN 55435
Phone: (952) 456-7136
Fax: (952) 944-0460

Updated: 8/9/2010