# Erie County Department of Health (ECDOH)
# Application for Internships/Clinical Rotations/Volunteer Positions

**Instructions:** Complete **all** sections below, print application and have your advisor sign it. Then, please scan and email this **application** along with a **cover letter**, **resume** and **letter of recommendation** to carlom@erie.gov.

ECDOH internships, clinical rotations and volunteer positions are not paid. Acceptance or denial is based on staff needs and availability. Correspondence will be sent to you indicating acceptance or denial. For questions, please call 716-858-2737 or email carlom@erie.gov.

Today's Date:

Type of position you are applying for:

- ☐ **Internship** (Select this if your College/University requires you to do this internship)
- ☐ **Clinical Rotation** (Select this if you are a nursing or medical student & your College/University requires you to do this rotation)
- ☐ **Volunteer** (Select this if you are not affiliated with a College/University or if your school does NOT require this internship/rotation)

Name:

Email:

Phone #:

College/University:

Major:

Name of the Program at your College/University that requires you to complete this internship:

Name of the School/Department at your College/University that the above Program falls under:

Is this internship/rotation required for you to graduate? ☐ Yes ☐ No Graduation Date (month & year)

Will you receive school credits for this internship/rotation? ☐ Yes ☐ No

Semester & Year you are requesting: ☐ Spring (Jan-May) ☐ Summer (June-Aug) ☐ Fall (Sept-Dec) Year:

Total number of hours you are requesting:

Days you can work: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

Hours you can work:

Select the ECDOH program(s) you are applying for:

**Internships & Volunteers:**

☐ Community Wellness ☐ Teen Wellness ☐ Epidemiology/Disease Control ☐ Environmental Health

☐ Community Health Assessment (CHA) ☐ Opiate Program ☐ Medical Examiner (Apply Here)

☐ Other (Click here for a complete list of programs & indicate program name):

***Clinical Rotations:*** ☐ *STD Clinic* ☐ *TB Clinic* ☐ *Family Planning Clinic*

Advisor Name:

Advisor Title:

Advisor Mailing Address:

Advisor Email:

Advisor Phone #:

**Student Advisor to complete this section:**

Will the College/University's liability insurance cover this student for this internship/clinical rotation? ☐ Yes ☐ No

Advisor Signature: