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

Instructions: Complete all sections and send 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. For questions, please 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: _____

Phone #: _____ Email: _____

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 applying for: ☐ Spring (Jan-May) ☐ Summer (June-Aug) ☐ Fall (Sept-Dec) Year: _____

Total number of hours you are requesting: _____

Days & hours you can work: ☐ Mon hrs _____ ☐ Tues hrs _____ ☐ Wed hrs _____ ☐ Thurs hrs _____
☐ Fri hrs _____ ☐ Sat hrs _____ ☐ Sun hrs _____

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

Internships & Volunteers:

☐ Community Wellness
☐ Environmental Health
☐ Epidemiology/Disease Control
☐ Opiate Program
☐ Health Equity
☐ Public Health Emergency Preparedness
☐ Medical Examiner (Apply Here)
☐ Other Program Name _____

Clinical Rotations:

☐ STD Clinic ☐ TB Clinic ☐ Family Planning Clinic

☐ Public Health Emergency Prep (vaccination clinics)

Student Advisor to complete this section:

Advisor Name: _____ Advisor Title: _____

Advisor Mailing Address: _____ City: _____ State: _____ Zip: _____

Advisor Phone #:_____ Advisor Email: _____

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

Advisor Signature: _____