

**UNPAID DEPARTMENTAL INTERNSHIPS**  
**(MORE THAN 3-DAYS)**  
**PAPERWORK CHECKLIST**

**Unpaid Internships at Upstate Medical University is the sole responsibility of the department hosting the individual (applicable to non-nursing departments only).**

If shadowing 3-DAYS OR LESS, visit our Job Shadowing page at  
[http://www.upstate.edu/hr/jobs/shadow\\_days.php](http://www.upstate.edu/hr/jobs/shadow_days.php)

Upstate's policy J-01 (<http://www.upstate.edu/intra/policy/pdf/J-01.pdf>) requires an Affiliation Agreement (contract ensuring liability coverage) with the school in which the individual is enrolled. **BEFORE** moving forward in this process, the department hosting the interning individual MUST verify with the Contract's Office that an affiliation agreement exists between the individual's school and Upstate Medical University. We **MUST** have an agreement for the individual to intern/shadow here.

**AFFILIATION AGREEMENT INFORMATION:**

Contracts Office  
Madison Towers, Room 209  
Phone: 315 464-4680  
Email: [corbettm@upstate.edu](mailto:corbettm@upstate.edu)

**ITEMS FOR INDIVIDUAL TO REVIEW/COMPLETE:**

- DETAILED HEALTH STATEMENT (internship is LESS THAN one month in duration) - OR - CERTIFICATE OF HEALTH STATEMENT (internship is MORE THAN one month in duration)**
  - Your name, date-of-birth, and today's date
  - Phone number where you can be reached
  - Start and Exit Date – date internship will begin; date internship will end
  - Job Title or Activity: Internship
  - Patient contact anticipated? Yes/No
  - Email address: email where you can be reached
  - Employer or Program: name of school you attend/your employer
  - Contact Person from Organization: contact person at the school you attend
  - Contact Person Phone No.: phone number for the contact person at the school you attend
  - Upstate Dept. or Program: department at Upstate you will be interning in
  - Contact Person at Upstate: person at Upstate that you will be interning
  - Upstate Contact Phone No.: phone number for the person at Upstate you will be interning
  - Please be sure to answer all questions on the health form (#1-3)
  - Sign Form
  - under 18 years of age, a parent/legal guardian must sign this form
  - **YOUR HEALTH CARE PROVIDER MUST COMPLETE THE SECOND SECTION \*\*SEE LAST PAGE OF THIS DOCUMENT IF COMPLETING THE CERTIFICATE OF HEALTH STATEMENT\*\***
  - **Return completed form to:**  
Employee/Student Health, Jacobsen Hall 4<sup>th</sup> Floor; Fax to 315-464-5471

**Risk Release Form**

- Read and sign/date
- **UNDER 18 years of age, a parent/legal guardian must also sign this form**
- **Return completed form to:**  
Contract's Office, Madison Towers Room 209; fax to 315-464-4679

**Confidentiality Agreement**

- Read and sign/date
- **Return completed form to:**  
Institutional Privacy Office, Widewaters Suite 130A; fax to 315-464-6131

**HIPAA Privacy Rule Education**

- Review content

**Completion Certificate: HIPAA Privacy Rule Education**

- Read and sign/date
- **Return completed form to:**  
Institutional Privacy Office, Widewaters Suite 130A; fax to 315-464-6131

**ID BADGE:**

- All non-employee badge requests must be requested through Self-Serve by the department hosting the individual.
- **The supervising manager** should visit <https://selfserve.upstate.edu/ais/applications/>. After logging in go to Applications and Non-Employee Management to access the electronic Non-Employee Online Request Form.
- Once a request for a non-employee badge is submitted via Self-Serve the manager hosting the individual will be instructed via e-mail to have the person report to either Employee Health Service for clearance or to Payroll for their ID Badge.
- For assistance, contact Sandra Delaney in Payroll Services at [delanesa@upstate.edu](mailto:delanesa@upstate.edu).

**PARKING:**

If the individual drives, they should park in the Visitor Garage/Upstate Parking Garage East. Enter via either the Sarah Loguen or Elizabeth Blackwell Street entrances. Parking fees are the responsibility of the individual. *The hosting department should contact the parking office for additional information; 464-4801.*

***\*\*If shadowing at the Community General Campus or an offsite clinic location, please discuss parking arrangements with the department hosting your shadowing experience.\*\****

**PLEASE NOTE:**

- **INDIVIDUAL MUST SEND A COPY OF ALL FORMS TO THE DEPARTMENT HOSTING THEIR INTERNSHIP** (*The department hosting the student is responsible to maintain documentation of required forms and forward copies to the appropriate departments*)
- **INDIVIDUAL SHOULD KEEP A COPY OF ALL FORMS FOR THEIR OWN RECORDS**

**\*\*ADDITIONAL INSTRUCTIONS – CERTIFICATE OF HEALTH STATEMENT\*\***

**YOUR PHYSICIAN OR HEALTH CARE PROVIDER SHOULD COMPLETE THE FOLLOWING:**

- \* **History and Physical.** You must either have a physical exam within one year of the start date or have had a physical exam > 1 year ago and documentation of subsequent annual health assessment(s) since your last physical. Significant health concerns must be stated.
- \* **Annual Health Assessment.** Submit documentation from present employer/health facility as explained above.
- \* **Health Limitations.** Do you have any health concerns that would prevent full participation or present a health risk to others?
- \* **Tuberculin Skin Test (TST).** A Mantoux (PPD) is required within one year of the start date if there is no prior history of a positive TST. Document the product used, lot number and expiration date. Document the result in millimeters. TST is required even if you have had BCG in the past. If the TST is positive or you have had a prior positive, a chest x-ray is required within six months of the start date.
- \* **Rubella.** An antibody(IgG) titer is required. If negative, one dose of vaccine is required?
- \* **Rubeola.** An antibody(IgG) titer is required if born after 1/1/57. If negative, two doses of vaccine are required 30 days apart.
- \* **Varicella.** An antibody titer is required if there is no history of disease. If the titer is negative, vaccine is suggested but not required.
- \* **Tetanus/Diphtheria.** Recommended within 10 years.
- \* **Patient Contact.** Have you received instruction and been fitted to wear a mask for respiratory protection?
- \* **Occupation Exposure.** Will your activities here potentially expose you to blood or body fluids?
- \* **Hepatitis B Vaccine.** Have you completed the series?
- \* **YOUR PHYSICIAN OR HEALTH CARE PROVIDER MUST SIGN THE CERTIFICATE OF HEALTH. THE NAME, TITLE ADDRESS AND TELEPHONE NUMBER MUST BE FULLY COMPLETED.**