University of Medicine and Dentistry of New Jersey

INTERNSHIP PROGRAM LEARNING AGREEMENT

INTERN INFORMATION			
First Name:	Last Name:	SS#:	
Address:	City:	State:	Zip:
Telephone #:	Email Address:		

DEPARTMENT INFORMATION		
Department:	Unit/School:	Campus:
Name of Supervisor:	Telephone #:	
Duration of Agreement: From To	Hours/Week:	

POSITION INFORMATION
Internship Proposal: (Include learning objectives of the internship, duties, responsibilities, and nature of activities to be performed)

REQUIRED SIGNATURES		
Role	Signature	Date
Intern		
Supervisor		
Dean/CEO/VP		
Human Resources		

Revised 3/2011