

**The Clinical Society of Queens & Long Island**

200-17 Linden Blvd, St. Albans, NY 11412

Tel:(718) 276-1353 Fax: (718) 276-1354

E-mail: [csqli@hotmail.com](mailto:csqli@hotmail.com)

Website: [www.clinicalsociety.org](http://www.clinicalsociety.org)

**Mentorship  
Summer Internship Program Application**

APPLICANTS MUST BE BETWEEN AGES FOURTEEN AND EIGHTEEN YEARS (14 -18).

Please Print Clearly

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name of High School: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Last Semester Grade Average \_\_\_\_\_

Science Courses Completed: \_\_\_\_\_

Guidance Counselor/Academic Advisor Name: \_\_\_\_\_

Hobbies/Interests: \_\_\_\_\_

Future Career Interest: (if Known) \_\_\_\_\_

Name of parent/Guardian: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_

**Please mail application with a letter of recommendation, signed parental consent, copies of working permit and valid ID.**

\_\_\_\_\_  
Applicant signature

**There will be a mandatory orientation before the program begin.**

**The Clinical Society of Queens & Long Island**

200-17 Linden Blvd, St. Albans, NY 11412

Tel:(718) 276-1353

Fax: (718) 276-1354

E-mail: [csqli@hotmail.com](mailto:csqli@hotmail.com)

Website: [www.clinicalsociety.org](http://www.clinicalsociety.org)

**Mentorship Program  
Parental Consent Form**

Please Print Clearly

I give permission for my son/daughter \_\_\_\_\_  
to participate in a clinical summer internship program under the sponsorship of The Clinical Society of  
Queens and Long Island.

I, \_\_\_\_\_ (student), understand that any fraudulent activity, theft or misconduct will  
be reported to the appropriate authority. Due to laws governing patient confidentiality, students are  
prohibited from disclosing a patient's private health information to any outside parties. For the purposes of  
research or other such reference, patient's names are not to be used. Any out office use of a patient's name,  
date of birth or social security number is considered fraudulent and a violation of the Federal Governments  
Health Insurance Patients Privacy Act.

---

Parent Signature	Print Name	Date
------------------	------------	------

---

Student Signature	Print Name	Date
-------------------	------------	------

Please fax or mail completed application, signed parental consent form, letter of recommendation, or current school report  
card to:

**CSQLI, 200-17 Linden Blvd, St. Albans, NY 11412**

**Fax: 718-276-1354**