GOAL Family Medical P.C.
Compassion. Dedication. Trust.

GOAL Family Medical P.C. is pleased to open our facility to this internship program with your school. We would like to take this time to welcome you and thank you for your participation. Please take a few moments to fill out the requested information below.

Name: _____

Phone Number: _____

Email: _____

Name of School: _____

Program : ☐ NP ☐ PA ☐ MA

Program Director or Professor: _____

Professor's Phone number:_____

Professor's Email: _____

Please generate your schedule in the space below!

GOAL Hours of Operation:

Tuesday:	8:30 AM - 6:30 PM
Wednesday - Friday:	8:30 AM - 4:03 PM
Saturday:	8:30 AM - 2:00 PM

Required # of hours _____

Start Date:_____ End Date: _____

Day	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours	⬜Unavailable ⬜Available From:_____ To:_____	⬜Unavailable ⬜Available From:_____ To:_____	⬜Unavailable ⬜Available From:_____ To:_____	⬜Unavailable ⬜Available From:_____ To:_____	⬜Unavailable ⬜Available From:_____ To:_____

444 Merrick Road, Suite LL3, Lynbrook, NY 11563
Tel: 516 758 7339 Fax: 516 758 7340
Email: admin@goalfamilymedical.com
www.goalfamilymedical.com

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Confidentiality Acknowledgement

I hereby acknowledge, that in accepting this position at GOAL Family Medical P.C., it is my responsibility to access and use confidential information in the course of my professional and job duties in an appropriate way. Confidential information includes but is not limited to information about patients, employees, volunteers and visitors. Confidentiality policies and procedures will be reviewed. Client information will not be disclosed in a common area with any unnecessary personnel in the room. Client information will not be disclosed to any other clients. All staff, students, and volunteers are directed to close or put away any client personal health information so it is not visible to any unauthorized personnel.

I understand that this release discharges GOAL Family Medical P.C. from any liability or claim that I may have against GOAL Family Medical P.C. with respect to any bodily injury, personal injury, illness, death or property damage. I also understand that GOAL Family Medical P.C. does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness. I hereby grant and convey unto GOAL Family Medical P.C. all rights, title, and interest in all photographic images, video or audio recording made by GOAL Family Medical P.C. We greatly appreciate your assistance and commitment to building a healthier community.

Name (In Print): _____

Signature: _____

Date: _____

Phone Number: _____

Email: _____

Name of School: _____

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If you have any questions or issues with scheduling, please contact:

Kendrea Scotland
Clinical Operations Manager
Phone Number: 929 359 3995
Email: goalfamilymedical@gmail.com

We wish you much success with your rotation and all of your future endeavors!

I, _____, have read and understood the forgoing requirements of being a part of the GOAL Family Medical P.C. team during my rotation. I understand that failure to comply with the guideline may result in the immediate termination of my rotation here at GOAL Family Medical P.C.

Signature: _____

Date: _____