



Snohomish County
Medical Examiner's Office
9509 29th Ave West, Everett, WA 98204
(425) 438-6200

INTERNSHIP AGREEMENT

By and between
 Snohomish County Medical Examiner's Office,
 _____ and

 (Intern)
 _____ on behalf of _____
 (Advisor) (Educational Facility)

This agreement is to confirm the unpaid Medicolegal Death Investigation Intern for _____ in the Medical Examiner's Office. _____ is receiving academic credit from the _____ for this internship.

_____ will be working directly with Robert Karinen and/or Jane Jorgensen and will be supervised by Heather Oie. Among other things, this internship will include working with the Medical Examiner's staff on the following projects:

The responsibilities of this internship include learning various forensic death investigation tasks to develop skills required to perform the duties of a Medical Investigator under the direction of the Medical Examiner's Office (MEO) staff. The incumbent will learn, practice, and assist with forensic investigations of deaths that fall under the jurisdiction of the Snohomish County Medical Examiner's Office, as well as assist the pathologist during examinations.

_____ will be working ____ hours per week from _____ to _____.

By the terms of this letter, the parties understand that this placement is primarily for the educational benefit of the intern. The focus of the internship will be on creating training experiences for the intern, not in enhancing productivity through the use of the internship program. The parties also agree that no regular Snohomish County employees will be displaced as a result of this internship. The parties further agree that in no sense shall the student/intern be considered an employee of the County, and he or she shall not be entitled to any wages, benefits or rights (including insurance, workers' compensation, leave and retirement benefits, or salary) enjoyed by employees of the County.

The parties also agree that the above named Educational Facility is authorizing this internship and is responsible for workers' compensation coverage. The parties further

understand that the student/intern is not necessarily entitled to a job at the conclusion of this placement.

____ *The proof of workers' compensations/facility medical insurance information and preferred service provider info must be submitted with this form.*

The parties further understand that this internship is subject to discontinuance at any time, without cause, at the discretion of Snohomish County. Nothing in this letter or any other written instrument shall be interpreted as modifying Snohomish County's unilateral right to cease this internship opportunity.

Thank you for participating in Snohomish County's Internship Program.

By signing this agreement, the parties represent that they understand and agree to the terms of the internship, as listed above. Please sign this agreement, and return to us by either fax or email. Fax to 425-438-6222 or email to Heather.Oie@SnoCo.org.

Medical Examiner's Office

J. Matthew Lacy, M.D., Chief Medical Examiner

Date

Educational Facility

Advisor

Date

Printed Name/Title

Student Intern

Date

Printed Name