Memorial Healthcare

Adult Job Shadowing Application

Student Information (please print)

Name: _____ Phone: _____

Race: _____ Previous Names: _____

Address: _____

City: _____ State: _____ Zip: _____

College attending: _____

Email Address: _____

Select top 3 choices and number (1, 2, 3) in order of your preference.

_____ Nursing	_____ Speech therapy	_____ Social Work
_____ Physical Therapy	_____ Respiratory therapy	_____ Radiology
_____ Computers	_____ Laboratory	
_____ Pharmacy	_____ Accounting	

Please describe your interests in healthcare, and why you want to job shadow.

Immunizations

Please list dates below and enclose proof of immunizations

Varicella (Chicken Pox)
1st: _____
2nd: _____

Tuberculin (TB/PPD)
Required EVERY year
Date: _____

MMR (Meases, Mumps & Rubella)
1st: _____
2nd: _____

Tdap (Tetanus, Diptheria, Pertussis)
Date must be within last 10 years:
Date: _____

Influenza (Flu shot)
Required Every year by Nov. 1
Date: _____

Hepatitis B
1st: _____
2nd: _____
3rd: _____

The following forms must be sent with this application

_____ Job Shadow Agreement
_____ Commitment Statement
_____ Confidentiality Agreement
_____ Proof of Immunizations
_____ Copy of driver's license

Mail or Email Completed Forms to:

Cindy George
Education Department
Memorial Healthcare
826 W. King St
Owosso, MI 48867

OR

cgeorge@memorialhealthcare.org

Applicants with missing forms or incomplete forms will not be able to job shadow. All job shadow experiences are assigned in the order in which they are received.

We will contact you via email with the assigned observation date.