Memorial Healthcare

Adult Job Shadowing Application - less than 16 hours

Student Information (please print)

Name: ______________________ Phone number: ______________

Address: ____

City: ________________ State: ______ Zip: ______

College: ________________

Email address: ______________________________

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

______	Nursing	______	Speech therapy
______	Physical Therapy	______	Respiratory therapy
______	Computers	______	Laboratory
______	Pharmacy	______	Social Work
______	Radiology	______	Physician Assistant/Medical Assistant/Nurse Pract.

Please describe your interests in healthcare and why you would like to job shadow.

Immunizations

Please list dates below and enclose proof of immunizations

Varicella (Chicken Pox)	**MMR** (Measles, Mumps & Rubella)	**Influenza** (Flu shot) Required Every year by Nov. 1
1st: ______	1st: ______	
2nd: ______	2nd: ______	Date: ______

Covid vaccine is not required do to the limited hours of the job shadow experience. If more than 16 hours is required, please contact Volunteer Services.

TB Screening

Proof of negative TB test within the past year

OR

Complete the following (Please check YES or NO to the following questions);

In the past year, have you had:

a. Unaccountable weight loss	______ Yes	______ No
b. Onset of chronic cough	______ Yes	______ No
c. Coughing up of blood	______ Yes	______ No
d. Chest pain on breathing	______ Yes	______ No
e. Night sweats	______ Yes	______ No
f. Unaccountable fever	______ Yes	______ No
g. A chest x-ray	______ Yes	______ No

If you answer YES to any of the questions above, please give an explanation below:

Please see next page

Name: ______________________________

The following forms must be sent with this application

__________ Job Shadow Agreement
__________ Confidentiality Agreement
__________ Proof of Immunizations

I understand that I will be participating in an observational experience at Memorial Healthcare. I release Memoiral Healthcare from all claims that may arise from this observational experience. I understand this is an observational experience only and there will be no patient care given by myself.

______________________________ ______________________________
Name (Printed) Signature

____
Date

Email completed forms to: tcoffman@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.