Memorial Healthcare

Job Shadowing Application - For Potential New Hire

Student Information (please print)

Name: ______________________________ Phone: ______________

Address: ____

City: ______________________ State: _______ Zip: ______________

Email address: ____

Department Job Shadowing: ____

Department Manager: ____

Immunizations

Please enclose proof of the following immunizations;
Please list dates below and enclose proof of immunizations

Varicella **(Chicken Pox)**
1st: __________
2nd: __________

MMR **(Measles, Mumps & Rubella)**
1st: __________
2nd: __________

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

Covid vaccine is not required do to the limited hours of the job shadow experience.

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:

Question	Yes	No
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
__________ Copy of Driver's License or State ID

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