West Holt Medical Services

JOB SHADOW APPLICATION

NAME: _____ DOB & AGE: _____

MAILING ADDRESS: CITY & STATE: ZIP CODE:

_____

CELL PHONE: _____

EMAIL ADDRESS: _____

HIGH SCHOOL / COLLEGE: _____

INTENDED CAREER / MAJOR: _____

EMERGENCY CONTACT

NAME: _____ PHONE: _____

THE FOLLOWING AREAS ARE AVAILABLE SHADOWING:

Please select the area you wish to shadow (choose 1)

_____ NURSING
_____ HOSPITAL ADMINISTRATION
_____ LAB
_____ PRIMARY CARE CLINIC PROVIDER
_____ INFORMATION TECHNOLOGY
_____ MEDICAL RECORDS
_____ RADIOLOGY
_____ NUTRITIONAL SERVICES
_____ OCCUPATIONAL THERAPY
_____ PHARMACY
_____ PHYSICAL THERAPY
_____ RESPIRATORY THERAPY
_____ SOCIAL SERVICES
_____ BUSINESS OFFICE

EMPLOYEE YOU WISH TO SHADOW: _____

WHY DO YOU DESIRE TO SHADOW THIS AREA / POSITION?

_____
_____
_____
_____

DATE YOU WISH TO SHADOW: (Please list in the order of preference)

1. _____ 2. _____ 3. _____

HR_Procedure_Onboarding/Offboarding
MKT_Form_Job Shadow Photo & Video Release
HR_Form_Job Shadow Release of Liability
HR_JA_Job Shadow Requirements