17-9515 Shadowing Observation Application

Number	36DAA82236	Maintainer	Allman, Chelsea A.
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SHADOWING/OBSERVATION APPLICATION

Name:	
Campus Address:	Major: Email Address:
Home Address:	Day Phone Number: Alternate Phone/Pager #: Date of Birth:
In an Emergency Notify: Name: Relationship to Shadower/Observer:	Phone: Cell: Other number:

JOB ROLE INFORMATION:

Job role you are requesting to observe/shadow:____

Requested date(s) for Job Shadowing experience:____

APPLICANT INFORMATION:

1. Name of School/College/University and Grade (Freshman, Sophomore, Jr. or Senior)

____

2. Which of the following do you wish to do (MUST pick one)?

- ☐ Observe – Observe/learn more about the healthcare field.
- ☐ Shadow – Shadow a healthcare professional. You must be a student of healthcare and the shadow experience must be part of an approved healthcare curriculum or be a non-affiliated professional to qualify for a shadowing experience.

DATE: Required	**TIME:** Required	**SIGNATURE:** Required

3. Have you applied or already been accepted into a college or university healthcare related program? If yes, please explain.

4. Is this a class or program requirement? ☐ Yes ☐ No (If yes, please explain requirement. Example: I need to observe 20 hours before I can be accepted into my major.)

If this is a class or program requirement, please provide contact information for the school or program:

______________________________	______________________________
Name of School or Program	Contact Name
______________________________	______________________________
Phone Number	E-mail Address

5. What do you hope to gain from a shadowing or observation experience at Charleston Area Medical Center, Inc.?

6. Have you ever been convicted or pled guilty to a violation, even if dismissed, of any law other than a minor traffic violation? ☐ Yes ☐ No

If yes, list the violation and date of conviction or plea:______________________________

____

7. Do you have someone who has agreed to allow you to shadow them?
☐ Yes ☐ No

If yes, please list name and telephone number of person below. If not, you will need to notify the Office of Learner Affairs to request assistance in identifying an appropriate person.,

Name:______________________________ Phone______________________________

DATE: Required	**TIME:** Required	**SIGNATURE:** Required