Job Shadow Program

Your information:

Name:_____ Email:_____

Address: City_____ State_____ Zip Code_____

Home Phone:_____

School:_____ DOB:_____ Cell Phone:_____

Emergency Contact Name:_____ Cell Phone:_____

The department you would like to shadow:_____

Dates and times you are available to shadow:_____

By my signature below, I confirm that I have read, understand, and agree to adhere to the conditions and policies of a CMH job shadow experience. I hereby agree that I will not disclose to anyone information concerning patients and patients' family members which I may acquire during the observation period.

_____ _____

Shadow participant signature Date

_____ _____

Parent/Guardian signature (if under Age 18) Date

Please sign and submit this page to the Human Resources Department at CMH at least 2 weeks prior to your requested shadow date:

***** If your job shadow experience will occur between October 1 and March 31, proof of a current flu shot must accompany this application.***