



# BOONE COUNTY HEALTH CENTER

## JOB SHADOW APPLICATION

Date of Application \_\_\_\_\_

NAME \_\_\_\_\_

\_\_\_Male \_\_\_Female Email Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

HomeAddress \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Phone Numbers \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency Contact Number \_\_\_\_\_

School/College \_\_\_\_\_ Grade \_\_\_\_\_

School Phone Number \_\_\_\_\_

If you are a minor – Name of Parent/Guardian \_\_\_\_\_

### Career Interests

List which departments you are interested in shadowing (e.g., Nursing, Physical Therapy).

\_\_\_\_\_  
\_\_\_\_\_

### Dates and Time you wish to shadow

\_\_\_\_\_  
\_\_\_\_\_

I hereby certify that the information contained on this form is true and complete. I hereby release the organization, and its employees for any claims of liability or physical injury as a result of my presence in the hospital, or clinical setting. I understand that placement for career exploration is at the discretion of the Boone County Health Center.

\_\_\_\_\_  
**SIGNATURE OF STUDENT SHADOW**

\_\_\_\_\_  
**DATE**

### PARENT/GUARDIAN CONSENT (if applicant is under the age of 18)

Your son or daughter has requested to Job Shadow at the Boone County Health Center (and/or Clinics). While he or she is shadowing they will also tour the area they are interested in, discuss a typical workday and explore different aspects of working in that particular career. As a student shadow to the Boone County Health Center (and /or Clinics), he or she will pledge to not disclose or discuss any patient confidential information with others, including friends or family, who do not have a need to know it. I understand that the Boone County Health Center has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. In order for your child to participate, this form must be filled out and returned to BCHC.

My son/daughter, \_\_\_\_\_,  
may shadow at the Boone County Health Center.

\_\_\_\_\_  
**SIGNATURE OF PARENT OR GUARDIAN**

\_\_\_\_\_  
**DATE**