# BOONE COUNTY HEALTH CENTER

## JOB SHADOW APPLICATION

Date of Application_____

NAME_____

☐Male ☐Female Email Address_____Date of Birth_____

HomeAddresss_____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**

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## 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**