

Memorial Healthcare
College or Adult Job Shadowing Application

Student Information (please print)

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

College: _____ Major: _____

Student email address: _____

Select top 3 choices and number (1, 2, 3) in order of your preference.

_____ Nursing	_____ Speech therapy
_____ Physical Therapy	_____ Respiratory therapy
_____ Computers	_____ Laboratory
_____ Pharmacy	_____ Social Work
_____ Radiology	_____ Physician Assistant/Medical Assistant/Nurse Pract.

Please enclose proof of the following immunizations;

Varicella (Chicken Pox): 2 doses or positive titer

MMR (Measles, Mumps & Rubella): 2 doses or positive titer

Tuberculin (TB/PPD): Negative test required within the last 12 months

Hepatitis B: 3 doses or positive titer

Tdap (Tetanus, Diphtheria, Pertussis): Must have received within the last 10 years

Influenza (Flu shot): Due November 1 through April 1

The following forms must be sent with this application

_____ Job Shadow Application
_____ Confidentiality Agreement
_____ Proof of Immunizations
_____ Copy of Driver's License

Student Signature

Date

Email Completed forms to tcoffman@memorialhealthcare.org

Applicants with missing forms or incomplete forms will not be able to job shadow. All job shadow experiences are assigned in the order in which they are received.