JOB SHADOW APPLICATION

Last Name:	First Name:	Middle Initial
Home Address:		
City, State, Zip:		
Home Phone:	Cell Phone:	
Email:	Date of Birth	
Name of School (f applicable):	Year in School (if applicable):	
If you are under 18, please list name and contact information for parent/legal guardian:		
Name:		
Relationship:	Contact #:	
Parent/guardian signature:		
Occupation or department you want to shadow:		
Name of person you would like to shadow with, if known:		
Briefly describe your reason for wanting to job shadow, including your learning and career objectives, number of hours you want to shadow, observational requirements, etc.		
What date(s) are you available for your job shadow?		
Emergency Contact Name (1):		
Relationship:	Phone:	
Emergency Contact Name (2):		
Relationship:	Phone:	
Do you have any limitations or special needs which need accommodation? Explain:		
Have you ever volunteered or been employed by Harrison County Hospital? If yes, when?		
Have you ever been arrested or convicted of a crime? List dates and charges.		
Do you have family members employed at Harrison County Hospital? Who?		
The information provided on this application is true and complete to the best of my knowledge.		
Signature:	Date:	