Shadowing Experience Request Form

Requestor: ***Please complete Sections A and B and submit at least 7 days prior to when you would like the experience to occur. Incomplete requests will be denied automatically.***

SECTION A: PARTICIPANT INFORMATION

Name: _____ Date of Birth: ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ School Affiliation: _____

Email: _____

Numbers of Days Requesting for Job Shadowing: _____

SECTION B: EXPERIENCE INFORMATION

Briefly describe why you are requesting the shadowing experience: _____

When would you like to begin your experience (must be a minimum of one week after request date)?

_____/_____/_____

Sponsoring Physician / Department: _____

Activities / Procedures you would like to observe: _____

Departments/areas in which shadowing is not permitted: (Facility excluded department/areas listed here)

DIRECTOR OF SPONSORING DEPARTMENT and if applicable Hospital CMO/CNO must authorize for the following departments; ED, OB/GYN, Mental Health and Surgery Areas

Date request received: _____/_____/_____ Approved ____ Denied _____

Reason for Denial: _____

Management Responsible for Participant while at Facility: _____

Hospital CMO/CNO Approval if applicable: _____ Date _____

SECTION C: HOSPITAL DETERMINATION

Human Resources – Background Verification: ____ Clear ____ Denied _____ N/A

Employee Health – Health Screening Verification: _____ Clear _____ Denied

Privacy Education – Privacy Training & Attestation: _____ Complete _____ Incomplete