Mercer Health

JOB SHADOWING/OBSERVATION QUESTIONNAIRE

Name:	**Age:**
Address:	
Phone:	**Email:**

Please list the department/s you are interested in job shadowing:	
Date & time available to shadow:	

- ☐ High School Student – Grade:_____
- ☐ College Student
  - ☐ Job shadow
  - ☐ Required observation for college requirement

Please list college:	
Please list program enrolled in:	
Please list number of hours needed:	

Parent signature needed for students under 18 years of age. Your signature indicates your approval for your child's participation in the Job Shadowing program at Mercer County Community Hospital and acknowledgment that he or she is in good health.

_____ _____

Parent Signature Date

- ☐ I have included both the confidentiality form and required proof if immunizations as listed on the Job Shadow Requirements.
- ☐ I have read the Job Shadowing Requirements and agree to abide by the stipulations set forth.

_____ _____

Student Signature Date