Bothwell Regional Health Center Job Shadow Application

Applicant's Name_____

Date of Birth_____ Age_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

Email Address_____

Preferred Contact Method_____

School Attending_____

Program / Major_____

Current Grade Level_____

Parent / Legal Guardian (if minor)_____

Contact Phone Number_____

Emergency Contact_____

Emergency Contact Phone Number_____

Department / Unit you are requesting to job shadow with_____

Total number of hour's requesting_____

First available date to job shadow (xx/xx/xxxx)_____

Please indicate below the times you are available for each day.

Monday_____Tuesday_____Wednesday_____Thursday_____Friday_____

Why are you interested in job shadowing with Bothwell Regional Health Center?

_____

_____

Are you a student in an accredited medical school? _____