

# MASON GENERAL HOSPITAL

901 Mt. View Drive, Building #1 • Shelton, WA • 98584 • (360) 426-1611

## JUNIOR JOB SHADOW APPLICATION

### PERSONAL DATA

PLEASE PRINT

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(LAST) (FIRST)

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
(STREET) (CITY) (ZIP)

NAME OF SCHOOL \_\_\_\_\_ PRESENT GRADE \_\_\_\_\_

YOUR OVERALL GRADE POINT AVERAGE \_\_\_\_\_

ARE YOU INVOLVED IN AFTER SCHOOL ACTIVITIES: I.E., SPORTS, CLUBS, JOB, ETC. THAT WOULD  
CONFLICT WITH PARTICIPATION IN THE PROGRAM? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, what are they?

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### INTERESTS

ARE YOU INTERESTED IN A SPECIFIC MEDICAL CAREER? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, WHAT FIELD?:

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IT IS NOT ALWAYS POSSIBLE TO ACCOMMODATE SPECIFIC DAYS OR HOURS BUT WE WILL TRY TO  
WORK WITH YOUR PREFERRED DAYS AND TIMES.

DAY(S) OF THE WEEK THAT YOU ARE AVAILABLE FOR OBSERVATION:

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HOURS AVAILABLE FOR OBSERVATION:

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Are you interested in being a Volunteer? \_\_\_\_\_

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### HEALTH

You will be required to have a Tuberculin Skin Test (T.S.T.). Our Employee Health Nurse will administer this free of charge. Since you are a minor, your parents will have to sign a TB consent form. You will be required to show verification of having received the Measles, Mumps and Rubella vaccine, or that you have gone through M.M.R. screening.

**IN CASE OF EMERGENCY, WHOM DO YOU WISH TO NOTIFY?**

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE \_\_\_\_\_

Are hours required for: Community Service \_\_\_\_ School Classes \_\_\_\_ Outside Activities \_\_\_\_

If yes to any of the above, please explain:

\_\_\_\_\_  
\_\_\_\_\_

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I UNDERSTAND THAT ALL THE INFORMATION WHICH I MAY HEAR DIRECTLY OR INDIRECTLY CONCERNING A PATIENT, DOCTOR, OR STAFF MEMBER, WILL BE CONSIDERED STRICTLY CONFIDENTIAL, AND I WILL NOT SEEK INFORMATION IN REGARD TO ANY PATIENT.

ALL STATEMENTS IN THE APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ANY INFORMATION SUBMITTED PROVES TO BE FALSE, IT SHALL BE CAUSE FOR DISMISSAL. I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION.

\_\_\_\_\_  
(Applicant's Signature) (Date)

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TO BE SIGNED BY PARENT(S) AND/OR GUARDIAN:

I GIVE CONSENT FOR MY DAUGHTER/SON TO JOB SHADOW AT MASON GENERAL HOSPITAL. I UNDERSTAND THAT JOB SHADOWING CAN LEAD TO EXPOSURE TO A VARIETY OF INFECTIOUS DISEASES. THESE INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING; HEPATITIS A, B, C, D, E, G, AND SIN-V, TUBERCULOSIS, HIV/AIDS, MENINGITIS, INFLUENZA AND OTHER BACTERIAL AND VIRAL INFECTIONS. \_\_\_\_\_ HAS MY (OUR) CONSENT TO SERVE AS A JUNIOR VOLUNTEER. WE UNDERSTAND THAT TRANSPORTATION TO AND FROM THE HOSPITAL IS OUR RESPONSIBILITY. WE UNDERSTAND WE NEED TO SIGN A TB CONSENT FORM AND WILL PRODUCE VERIFICATION OF THE MEASLES, MUMPS AND RUBELLA VACCINE OR RUBELLA SCREENING AS REQUIRED.

\_\_\_\_\_  
(Parent and/or Guardian Signature) (Date)

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-FOR OFFICE USE ONLY-

INTERVIEWED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

Hospital Orientation Date: \_\_\_\_\_ TB Consent: \_\_\_\_\_ Orient to Position Date: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

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