MASON GENERAL HOSPITAL

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

ADULT JOB SHADOW APPLICATION

PERSONAL DATA

PLEASE PRINT

NAME ____ DATE OF BIRTH ___________
(LAST) (FIRST)

ADDRESS ____ HOME PHONE ____________
(STREET) (CITY) (ZIP)

ARE YOU INVOLVED IN ANY 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(s)?:

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:

HOURS AVAILABLE FOR OBSERVATION:

ARE YOU INTERESTED IN BEING A VOLUNTEER? YES ______ NO ______

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HEALTH REQUIREMENTS

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

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

NAME: ______________________________ RELATIONSHIP: ___________ PHONE ___________

NAME: ______________________________ RELATIONSHIP: ___________ PHONE ___________

If observation hours required for a college course 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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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.

____ ________________

(Applicant's Signature) (Date)

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-FOR OFFICE USE ONLY-

INTERVIEWED BY: ______________________________________DATE: ____________

Hospital Orientation Date: ________ TST DATE: _______ Orient to Position Date: __________

COMMENTS:

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