Shadowing Student Application

Today's Date:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____

Please specify which type of healthcare professional(s) you would like to shadow:

- ☐ Dental
- ☐ Family Medicine, DO
- ☐ Family Medicine, MD
- ☐ Nursing
- ☐ Pharmacy
- ☐ Physician Assistant
- ☐ Public Health
- ☐ Other: _____

Hours Needed/Desired: _____

Date you want to start: _____ Date hours need to be completed: _____

What days work for your schedule? (M-F, Morning (8-12) or Afternoon (1-5)):
Please note that hours in the main clinic will be limited from June-October due to other medical students completing required rotations. (One ½ day per week) _____

_____

_____

What days absolutely won't work with your schedule?: _____

_____

What are your objectives of this experience? (Observation, requirement, school project, etc.)

_____

_____

_____

_____

#1) Age Requirement: All shadow students must be over the age of 16 (18 under must have parent/guardian permission). No student under the age of 18 may shadow in the RiverStone Heath Clinic for confidentiality concerns, under 18 may shadow other departments per approval. Birthdate: _____

#2) Healthcare Career Aspirations: What are your healthcare career plans?: _____

_____

_____

_____

What is your previous experience with primary care and care of underserved populations?

_____

_____

_____

_____

#3) RiverStone Health Connections. Did anyone from RiverStone Health refer you to our shadowing program? _____

_____

☐ *By checking this box, I agree to allow RiverStone Health to contact me regarding job openings.*

#4) If you are CURRENTLY enrolled in a school and need hours for a class or course please complete:

Name of School: _____ Year in School: _____

Class/Course: _____ Hours Needed: _____

Instructor/Advisor Name: _____

Instructor Email: _____

#5) Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, provide a date and explanation: _____

_____

***All students shadowing during flu season (October 1 – March 31) are <u>required</u> to provide proof of current flu shot or a valid written medical declination form signed by an MD or DO physician.*

Required for Demographic (Grant) Use Only:

Gender Identity: _____

Age Range (in years): <20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ 60+ ☐

Ethnicity: Non-Hispanic ☐ Hispanic ☐

Race: _____

Hometown: _____ Is it Rural? _____

1st Generation College Student? ☐ Yes ☐ No

**Are you the first in your immediate family to attend college?*

I hereby attest that all of the above information is true and complete. I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for a student experience at RiverStone Health.

_____ _____

Signature of Student *(Typed is acceptable for online forms)* Date

_____ _____

Signature of Parent (if student is under 18 years of age) Date
(Typed is acceptable for online forms)

Thank you for your interest in RiverStone Health!

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