Shadowing Student Application

Name: _____ Today's Date: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

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: _____

Date you wish to start: _____ Hours needing to complete: _____

What days/times work for you? (Monday – Friday; Morning (8am-12pm), Afternoon (1-5pm) or Specific Times):

What days will NOT work for you?

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

1) Age Requirement: All shadow students must be over the age of 16 (Under 18 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) Immunization Requirements: The following immunization records will be required to shadow through RiverStone Health. *Policies and exemption forms can be requested.*

- TB (Tuberculosis) – Proof of Negative Test
- MMR (Measles, Mumps, Rubella)- Proof of vaccination
- Flu Vaccination or approved exemption *(required from December 1 – April 1)*

3) Have you ever been convicted of a felony? ☐ YES ☐ NO
If yes, provide a date and explanation:

4) Healthcare Career Aspirations: What are your healthcare career plans?

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

6) RiverStone Health Connections. *Were you referred by anyone at RiverStone Health?*

7) 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 & Contact: _____

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?*

☐ *By checking this box, I agree to share my contact information with RiverStone Health Human Resources for future job opportunities.*

I hereby attest that all 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 the 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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