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
- ☐ Nurse Practitioner
- ☐ Pharmacy
- ☐ Pharmacy
- ☐ 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 Health 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.

- TB (Tuberculosis)
  - Two-Step screening is needed within 12 months of training program start date.
  - IGRA Blood Test within 12 months of training program start date (QuantiFERON) or T-Spot)
  - If prior (+) TB test, documentation of clear chest X-ray within the past 2 years and annual TB screening quesxtionnaire.
- MMR: (Measels, Mumps, Rubella) - Proof of vaccination
- Influenza Vaccination during Flu season - September 15 - March 31

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 for 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!

Nikole Bakko, Outreach Coordinator
Eastern MT AHEC at RiverStone Health
Nikole.bak@riverstonehealth.org
Office: 406.247.3284