**Reading Hospital Job Shadowing Application**

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| Name: |  |
| Age: |  |
| Email: |  |
| High School / College |  |
| Current Grade / Year |  |
| Parent/Guardian Name: |  |
| Phone Number: |  |
| Department you would like to shadow under: |  |
| Please provideavailable dates and times that you are able to participate in a shadowing experience. ***(Be Specific)**** Proposed shadowing dates and times should not be expected to occur prior to 30 days after submitting this form.
* The shadowing experience will last a ***maximum of 4 hours,*** with the opportunity to shadow twice per calendar year.
* Start times should begin anytime between (8:00am-4:00pm).
* Weekend observations are not permitted unless otherwise discussed.
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| Date | Time |
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| By Signing this form you agree to follow the shadowing policy and confidentiality agreement.Also, you are agreeing to complete a shadowing survey to provide feedback on your experience.Signature: Date: Parent or Guardian Signature: Date: Completed forms can emailed to Brandon.monk@towerhealth.org or Faxed (484-628-9598) Attn: Brandon Monk. If you would like to drop-off the forms at the Hospital, please contact Brandon Monk, Community Health Coordinator at (Brandon.monk@towerhealth.org or by phone 484-628-4977) to schedule a drop-off time. |