Job Shadow Request Form

PERSONAL INFORMATION				
LAST NAME:		FIRST NAME:		MI:
PERMANENT ADDRESS:		CITY:	STATE:	Zip
PHONE NUMBER	DATE OF BIRTH	EMAIL ADDRESS		

SCHOOL INFORMATION (NOT REQUIRED)			
SCHOOL:		Program/Major (be as specific as possible; ex: Nursing – RN)	
INSTRUCTOR/COUNSELOR/ADVISOR	START DATE:	END DATE:	NUMBER OF HOURS DESIRED:

*Job Shadows are a maximum of 2-4 hours

AREAS YOU WISH TO SEE: List your preference and if more than one field of interest, rank number 1-3 in order of preference.

____ ATHLETIC TRAINER	____ LABORATORY	____ PHYSICAL THERAPY
____ AUDIOLOGY	____ MARKETING/COMMUNITY RELATIONS	____ PHYSICIAN
____ BUSINESS OFFICE	____ MEDICAL CODER – HEALTH INFO MGMT	____ PHYSICIAN ASSISTANT
____ CARDIAC REHAB	____ NURSE PRACTITIONER	____ RADIOLOGY
____ DIETETICS (NUTRITION SERVICES)	____ NURSING/NURSING ASSISTANT	____ RESPIRATORY THERAPY
____ HEALTHCARE ADMINISTRATION	____ OCCUPATIONAL THERAPY	____ SOCIAL WORK
____ HUMAN RESOURCES	____ PHARMACY	____ WELLNESS COACH

**If you do not see your fields listed, please contact the Education Coordinator at (608) 643-7291.

DATE YOU WISH TO SHADOW: Please list 3 dates at least two weeks from now in order of preference. If only specific hours work on these days, please note it here.

1. _____ 2. _____ 3. _____

EMERGENCY CONTACT		
LAST NAME:	FIRST NAME:	
RELATIONSHIP:	PRIMARY TELEPHONE NUMBER:	Secondary Telephone Number:

STUDENT SIGNATURE _____ DATE _____

EDUCATION USE ONLY

DEPARTMENT DIRECTOR CONSENT	☐	CONFIDENTIALITY FORM	☐
NAME BADGE MADE	☐	HEALTH HISTORY & ORIENTATION (IF REQUIRED)	☐
SPH DEPARTMENT:	_____	NAME OF EMPLOYEE:	_____

EDUCATION COORDINATOR SIGNATURE _____ DATE _____

Return the completed form to: Sauk Prairie Healthcare, Attn: Education Department, 260 26th St. Prairie du Sac, WI 53578
ed@saukprairiehealthcare.org