Job Shadow Request Form

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

SPH Employee Y or N if so where

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
______ Other		

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:

JOB SHADOW SIGNATURE ______________________ DATE ______________________

EDUCATION USE ONLY			
DEPARTMENT DIRECTOR CONSENT	☐	CONFIDENTIALITY FORM	☐
NAME BADGE MADE	☐	HEALTH HISTORY & ORIENTATION (IF REQUIRED)	☐
		COVID-19 VACCINE DOCUMENTATION (IF VACCINATED)	☐
SPH DEPARTMENT:		NAME OF EMPLOYEE:	
EDUCATION COORDINATOR SIGNATURE/HUMAN RESOURCES SIGNATURE		DATE	

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