UPMC
LIFE CHANGING MEDICINE

UPMC Shadow Program Application

Name: _____

Address: _____

Telephone Number: _____ Email Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Telephone Number: _____

1. Have you shadowed at a UPMC owned and/or operated facility before? Yes No
   a. Year_____ Facility_____ UPMC Department_____
2. Are you a current student? (if no, skip to question number 6) Yes No
3. If yes, are you a college or high school student?
   _____
4. Where are you currently attending school? _____
5. What is your student status (freshman, sophomore, junior, senior, Graduate)?
   _____
6. What UPMC Facility are you interested in shadowing at? _____
7. What are your preferred dates and times for a shadow experience? (**Must not exceed 2 weeks**)

Please provide availability for at least thirty days from now.

Shadow experiences can be scheduled Monday through Friday 8AM-5PM. **No weekends or Holidays

Date: _____ Time: _____

Date: _____ Time: _____

8. Which specialty area(s) are you interested in shadowing (Imaging, Surgery, etc.)?
   a. _____ c._____
   b. _____ d._____
9. Have you already spoken to a UPMC employee about shadowing? Yes No
10. What do you hope to gain from this experience?
    _____
    _____
    _____