

Student Job Shadow Application UPMC Northwest

To Be Completed by Student: **Please Print**

Name: _____

E-mail: _____

Home Phone () _____ Cell Phone () _____

Date of Birth: _____ Age: _____

School _____ Present Grade/Level: _____

Where do you wish to shadow? () **UPMC Northwest** () **UPMC Primary Care-outpatient**
() **UPMC Specialty Care-outpatient**

If outpatient, which location would you would like to shadow: _____

*areas available are Seneca, Franklin, Clarion

If inpatient, what department would you like to shadow: _____

List **2 preferred dates** you are available: _____

Purpose of job shadow: _____

If I am placed in UPMC's Student job shadow Program, I agree to the following:

1. I shall abide by the UPMC Visitor Confidentiality Agreement which was provided to me at the time of application.
2. I hereby understand and accept this mentorship with UPMC as described to me by my hospital supervisor and/or my school regulations. I hereby release UPMC from any or all liability arising from or in any way connected to the mentorship.

Student Applicant Signature

Print

Date

To be Completed by guidance counselor if under 18 and missing school:

Name: _____ Phone: () _____

School Counselor signature: _____

*Parent or Guardian signature: _____

*required if under 18

Please complete and return forms to:

Kate Hall at:

hallk17@upmc.edu