TRINITY HEALTH SYSTEM
STUDENT JOB-SHADOWING
PROGRAM APPLICATION

Name____Date___________
(last) (first) (middle)
Address_______________________________City_______________State_______
Birth Date________________Home Phone___________Work Phone____________
If employed, name of firm___________________________Phone______________
Contact in case of emergency____

(name) (relationship) (home phone) (work phone)

Why are you interest in participating in the shadowing program?

High School/College attending____

Signature____

Signature____
(Parent signature if under 18 years of age)

CONFIDENTIALITY STATEMENT

I understand and agree that in the job-shadowing program at Trinity Health System, I must hold in strictest confidence any observations I may make or hear regarding clients, client families, of staff.
I understand that intentional or involuntary violation of confidentiality may result in disciplinary action, including termination, by Trinity Health System and/or possible legal action (i.e., clients, families of clients, ect.)

Applicant's Signature______________________________________Date________

Hospital Department____
Date__________________________Hours Shadowed______________________

Department Employee Signature____

When the individual has completed the shadowing, please return this to the Volunteer Office at the East Campus.