



TriHealth Job Shadow Application

A Job Shadow Experience is intended to be observational only and is typically for one session of up to 8 hours (ER and NICU may be less). Longer requests may be possible but must be pre-approved by the person to be shadowed and the manager of the specified department/unit/practice. In order to fulfill a job shadow opportunity at TriHealth, you must start with the following steps:

- 1) Obtain a commitment from a TriHealth team member/affiliated provider who will host your experience – if you have not already identified someone, please see the shadowing page at <https://www.trihealth.com/research-and-education/education/job-shadowing> for suggested steps
- 2) Obtain approval from the manager of the specific unit, department, or physician practice

Shadow Applicant Details

___Mrs. ___Mr. ___Miss ___Ms. AGE _____(must be at least 15 yrs)

Name _____
Last First Middle

Address _____
Number/Street Apt. # City State Zip Code

Contact number (w/area code): _____ Email: _____

Educational Background (indicate number of years completed)

High School __1 __2 __3 __4 College __1 __2 __3 __4 _____
Name of High School

Graduate _____ Business/Trade _____
Name of College/University Name of School

Person To Be Notified in Case of Accident or Emergency: _____

Relationship: _____ Contact # _____

I, shadow applicant, hereby consent to follow all rules set forth in this job shadowing experience. I acknowledge that I must act responsibly and professionally in this role. I also understand that I am only an observer and I am not permitted to act in any capacity other than that of observer.

_____ Shadowing Applicant

_____ Date



If under 18 years of age, parent or guardian must complete:

I, the undersigned, herewith consent that _____ may observe at the health care facility assigned for a job shadowing experience, and I expressly release that institution from any and all claims which arise out of the observation experience.

X

Parent of Applicant, sign and date

Details of the TriHealth Team Member/Affiliated Healthcare Provider You Wish to Shadow

Note: omitting any information requested will result in approval delays

Name and role/title of individual: _____

Location:

___ Bethesda North Hospital; unit/department: _____

___ Good Samaritan Hospital; unit/department: _____

___ Provider Office; name & location: _____

___ Other: _____

Name of unit/department Manager or Practice Administrator: _____

Number of hours requested for shadowing: _____ Tentative Date Scheduled: _____

(note: date scheduled is contingent upon review of required items and approval; please allow at least 2 weeks from date of submission of all shadowing application requirements)

Submitting Application and Additional Documentation

Save the completed application to your computer and email it with the documents listed below to job_shadows@trihealth.com

- ✓ Signed Risk and Release Form
- ✓ Permission to Treat Minors Form (if applicable to age), signed by parent/guardian
- ✓ Immunization records/proof of vaccination
- ✓ Documentation of negative TB results
- ✓ ELearn certificate

(Specific forms may be found at <https://www.trihealth.com/research-and-education/education/job-shadowing>, as well as the **Job Shadow Instructions** document with more details about required health documentation, Elearning, etc.)