HRMC
Huron Regional Medical Center

Job Shadow/Observation Agreement

Name: ____
(Last) (First) (Middle)

Home Address: ____
(Street) (City) (State) (Zip)

Phone: (____) ________________ **Email Address**:______________________

Birth date: _______________ **Present Age**__________ **Sex:** ___Male ____Female

Daytime Phone Number: (____) _________ **Alternate Phone Number**: (____) _____________

Best time to contact: ____

If under age 18, Parent(s) or Guardian:______________________________

Name/Location of School Currently Attending:______________________

____
(Street or PO Box) (City) (State) (Zip)

Circle school status: High School or College Freshman Sophomore Junior Senior Other

Careers interested in Shadowing/Observing:

____

To be completed by Applicant:

I agree to:

- ❑ Complete Medical History Questionnaire (attached)
- ❑ Complete Confidentiality Education and Testing
- ❑ Follow dress code
- ❑ Exercise professional behavior in the hospital environment

I certify that the information given in this application is true and correct. I have proofread for accuracy and completeness. I have read and understand the Shadow Experience Procedure/Policy and will abide to what it states. I will adhere to the HIPPA policy and not discuss anything related to patients or hospital privacy outside of the experience. I understand removal from the facility or other forms of action may be taken if I do not adhere to the policies I have reviewed. HRMC is not responsible for injury or illness or costs involved with any type of follow up care. HRMC is not responsible for personal property brought onto the site. I will call ahead if unable to attend the scheduled experience.

____
Signature of Applicant **Date**

____
Signature of Parent or Guardian (if under age 18) **Date**

Print and complete this form and return to: 172 Fourth Street SE Huron, SD 57350 or dbrock@huronregional.org.
Call Dennise Brock at 353-6326 with questions.