BUTLER COUNTY HEALTH

Job Shadow Application

Student Information

Name:_____ Date of Birth:_____

Cell Phone:_____ Email:_____

School:_____ Grade:_____

Emergency Contact

Name:_____ Relationship to Student:_____

Cell Phone:_____

Please list up to three health care departments you wish to job shadow. (Nursing, Occupational Therapy, Physical Therapy, Speech Therapy, Radiology, Pharmacy, Cardiopulmonary or Laboratory. If other profession please list)

1._____

2._____

3._____

Please explain why you are interested in the job shadow experience at Butler County Health.

What do you hope to learn during your job shadow experience?