Observation/Shadowing Application

NAMC/Shoals Hospitals

(Please Print)

Name: _____ Birth Date: _____

Home Address: _____ City: _____ State: _____

Home Phone: _____ Cell Phone: _____

Email: _____ School: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Observation/Shadowing Request

☐ NAMC ☐ Shoals Hospital ☐ NAMC Cloyd Campus ☐ J.W. Sommer's Rehab Department: _____

Start date: _____ End date: _____ Total Hours Requested: _____

Reason for Observation/Shadowing Request: _____

_____

_____

If you have pre-arranged observation/shadowing time with a physician or employee:

Physician/Employee Name: _____ Unit/Dept: _____

I certify that the statements made in this Observation/Shadowing Application are true, correct and complete. I understand that this information may be disclosed to any party with legal and proper interest, and I release the hospital from any liability whatsoever for supplying such information.

I understand that it is my responsibility to assume financial responsibility for expenses associated with any personal accident or injury that may occur while at NAMC/Shoals Hospital, and that any illness or injury shall be reported immediately to my preceptor.

I understand that the observation/shadowing experience may be discontinued, without cause, at any time by NAMC/Shoals Hospital or by the observer.

I understand that I will provide proof of a current TB skin test (administered within the last 12 months) and will complete required HIPAA Training and Observation/Shadowing Student Hospital Orientation training upon approval of this application.

_____ _____

Signature Date

NOTE: IF OBSERVATION/SHADOWING STUDENT IS UNDER THE AGE OF 18, A PARENT OR GUARDIAN MUST SIGN THE FOLLOWING STATEMENT OF CONSENT:

I give consent for my son/daughter to participate in the Observation/Shadowing Program at ECM/Shoals Hospital. I authorize physicians at NAMC/Shoals Hospitals to administer medical treatment in case of emergency. I will encourage my son/daughter to be prompt and dependable while observing/shadowing. I understand that Observation/Shadowing students are required to provide proof of a current TB test.

_____ _____ _____

Signature Relationship Date

Return completed Observation/Shadowing Application to Tammie Holt, NAMC Education Department.

The following is to be completed by the Hospital Coordinator:

Approved: ☐ YES ☐ NO By: _____ Date: _____