



Shadow Experience Interest Inventory & Authorization to Participate

Thank you for your interest in the Regional West Shadow Experience Program. We are excited that you are interested in a possible career in the medical field. Please complete this form with appropriate parental approval, as needed, and return the form to the **Nebraska Panhandle Area Health Education Center** 2620 College Park, Scottsbluff, NE 69361 or Fax 308-632-0415.

Student Name: _____ Grade: _____

Street Address: _____ High School/College: _____

City, State, Zip: _____ Date of Birth: _____

Phone number: _____ Email: _____

Please list your primary areas of interest:

1. _____ 3. _____

2. _____ 4. _____

Please share your career goals and interests: _____

Do you have a health care professional(s) in mind who you would like to shadow?

What do you hope to learn in your experience?

Please identify the potential date(s) that would best for your shadow experience (please list several if possible.) Please note we cannot guarantee your dates.

Acknowledgement of Student:

I understand and agree to maintain patient confidentiality and adhere to the established dress standards that have been identified to me. I recognize that I may be exposed to potential risks as a result of this experience and will not hold Regional West Health Services liable for any injury as the result of this experience.

Student's Signature: _____

Date: _____

Permission of Parent (required of any Student under the 19)

I grant my child, _____, who is 16 years of age or older, permission to participate in the approved Regional West Health Services Shadow Experience. I understand that he/she may be exposed to patient information and that we are responsible for keeping it confidential. I also recognize that he/she may be exposed to potential risks as a result of this experience and agree to not hold Regional West Health Services liable for any harm or injury as a result of this experience.

Parent/Guardian's Signature: _____

Date: _____

Approved Department: _____ Date/Time: _____

Director's Signature: _____ Approved Mentor: _____