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: _____

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Approved Department: _____ Date/Time: _____

Director's Signature: _____ Approved Mentor: _____