



# MARY LANNING HOSPITAL JOB SHADOWING REQUEST

Applications must be received a minimum of 3 weeks prior to the requested date.

Name: \_\_\_\_\_ (Please Print)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School Phone: \_\_\_\_\_

High School: \_\_\_\_\_ Grade Level:  Senior

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Counselors Name: \_\_\_\_\_

Shadowing Date and Time Requested: \_\_\_\_\_

Shadowing Interest: \_\_\_\_\_ Nursing \_\_\_\_\_ Pharmacy  
 \_\_\_\_\_ Cardiopulmonary \_\_\_\_\_ Physical Therapy  
 \_\_\_\_\_ Laboratory \_\_\_\_\_ Other  
 \_\_\_\_\_ Radiology

**Write a paragraph on the second page of this paper stating your reasons for requesting this job shadowing experience. Include what experiences you hope to gain and course objectives if applicable. (Required.)**

### PARENTAL CONSENT

I, \_\_\_\_\_ give my consent for \_\_\_\_\_  
(parent/legal guardian) Student

to participate in the Mary Lanning Memorial Hospital Job Shadow Program and release the hospital of any liability while my son/daughter is on hospital grounds. In addition, I verify that my son/daughter has the following up to date Immunizations: Measles, Mumps & Rubella (MMR), Chicken Pox (Varicella) or history of the disease and Tetanus/Diphtheria.

\_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### COUNSELOR RECOMMENDATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form to: Attn: Jodi Sowl / Dept. of Education  
Mary Lanning Memorial Hospital  
715 North St. Joseph  
Hastings, Nebraska 68901

